STATEMENT OF CONSIDERATION RELATING TO
907 KAR: 12:010

Department for Medicaid Services
Amended After Comments

(1) A public hearing regarding 907 KAR 12:010 was requested and held. The following individuals submitted comments at the hearing:

Name and Title	Organization/Agency/Other Entity
Marc A. Scureman, Parent Shannon McCracken, Interim Executive Director	Kentucky Association of Private Providers (KAPP)
Jean M. Russell	Vice President, Developmental Services, Seven Counties Services
Lili S. Lutgens, JD, LCSW	Therapeutic Intervention Services, PLLC
Christopher D. George, M.Ed., BCBA, LBA	Owner/Executive Director Applied Behavioral Advancements, LLC
Johnny Callebs	Regional/Executive Director Independent Opportunities-Richmond
Chris Stevenson Jodi Wilson, Regional Director	ResCare

(2) The following individuals submitted written comments regarding 907 KAR 12:010:

Name and Title	Organization/Agency/Other Entity
Dawn Easterling	Family member/co-guardian of recipient
Shawn Lewis	Family member/co-guardian of recipient
Robin Lanier	Family member of recipient
Johnny Callebs	Regional/Executive Director Independent Opportunities-Richmond
Jane Rainey	Mother/Guardian
Karen Gardner	Tri-Generations
Melissa Renn Brown	Executive Director/Program Director, SCL and MPW Waiver Services, Down Syndrome of Louisville, Inc.
Jean M. Russell	Vice President, Developmental Services, Seven Counties Services
William S. Dolan	Staff Attorney Supervisor, Protection and Advocacy

Jan Eblen	President, Kentucky Association for Community Employment Services
Christopher D. George, M.Ed., BCBA, LBA	Owner/Executive Director Applied Behavioral Advancements, LLC
Lili S. Lutgens, JD, LCSW	Therapeutic Intervention Services, PLLC
Therapeutic Intervention Services, PLLC	Therapeutic Intervention Services, PLLC
Tanya Dickinson	Department for Behavioral Health, Developmental & Intellectual Disabilities
Steve Shannon, Executive Director	Kentucky Association of Regional Programs
Jodi Wilson, Regional Director	ResCare
Shannon McCracken, Interim Executive Director	Kentucky Association of Private Providers (KAPP)
Brittany Knoth, Executive Director	Path Forward of KY
Robert J. Illback, PsyD, ABPP, President and Chief Executive Officer	REACH of Louisville
Stephen S. Zaricki, MSW, Executive Director	Community Living, Inc.
David Coons	Family Home Provider
Meghen Wilson	Growing Minds Learning Center
Jenifer C. Frommeyer, Executive Director	Dreams With Wings
Leah F. Campbell, JD, Chief Operating Officer	Apple Patch Community
Tomika H. Cosby, Executive Director	Kentucky Case Management
Steve Frommeyer	Parent of a recipient of waiver services
Leigh Denniston	Almcare
Diane Quarles-Hartman, BS/MHA, Executive Director	Evergreen Life Services
Pamela J. Millay, R.N., J.D, Clinical Director/ CPO	Redwood
Myra Gribbins, Owner/Executive Director	Reach for the stars Case Management
Brad Schneider Vice President, Developmental Services Division	LifeSkills, Inc.
Lisa A. (Chaplin) Wise, BS Special Edu, Assistant Director	Communicare
Maria Alagia Cull	ResCare

(3) The following individuals from the promulgating agency responded to comments received regarding 907 KAR 12:010:

Name and Title	Organization/Agency/Other Entity
Claudia Johnson, Assistant Director	Division of Developmental and Intellectual Disabilities, Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID)
Alice Blackwell, Assistant Director	Division of Developmental and Intellectual Disabilities, Department for

	Behavioral Health, Developmental and Intellectual Disabilities (DBHDID)
Earl Gresham, Assistant Director	Department for Medicaid Services, Division of Community Alternatives
Stuart Owen, Regulation Coordinator	Department for Medicaid Services, Commissioner's Office
Jonathan MacDonald, Internal Policy Analyst III	Department for Medicaid Services, Commissioner's Office

SUMMARY OF COMMENTS AND AGENCY'S RESPONSES

(1) Subject: Case Management

(a) Comment: Dawn Easterling and Shawn Lewis, made the following comment:

"We are caregivers/co-guardians for our brother, David Porter. He has been receiving services from Pathways for over 30 years. We have been informed of the change in legislation that might be happening concerning not having a case manager with the same place he is receiving services. This would be devastating to David. We would have to move him from the ADT to another place to receive services somewhere else or give up his case manager. We absolutely will not give up our case manager, DeeDee Willis. She is the only one we have had in over 20 years that will do her job right and puts David's needs first. My brother is autistic and change is not good for him. He only receives 18 hours per week at the ADT he currently attends and he receives SCL services. We currently have an exemption for conflicted case management. And at the same time, you are taking away his rights to receive services where he wants and keep his case manager, both of whom he is very familiar with. We urge you to vote against this.

Thank you for your attention to this matter."

(b) Response: The Supports for Community Living (SCL) regulation does not preclude a participant's choice of case manager but rather only requires that case management be conflict-free as mandated by the federal agency (Centers for Medicare and Medicaid Services or CMS) which provides funding for the program.

An exemption is possible if the provider is the only willing and qualified SCL provider within 30 miles of the participant's residence as evidenced by documentation of the lack of willing and qualified providers. As noted, the requirement for conflict free case management is a federal requirement imposed by CMS. CMS issued a final regulation for all 1915 (c) waivers which can be found here: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-SupportS/Home-and-Community-Based-Services/Home-and-Community-Based-Services.html.

(a) Comment: Robin Lanier made the following comment:

“My name is Robin Lanier and I have a daughter that receives services through the SCL Wavier now known as SCL 2. I would like to have a voice in the changes that affect my family and others before the regulations are passed. I would like to tell you some of the things that have worked and not worked for us. Thank you for this opportunity.

1. One of the things that has been successful is having the choice of traditional and CDO services.
We have had services both ways and it has been much more successful for our family to have blended services.
2. Before we decided to go CDO with respite and PDS we had agencies. It did not work well. One reason is because most agencies want to send whoever they have available. Most consumers need and want consistency. Also they wanted to come at their convenience and not the times that the consumers wanted or needed them. I like having the flexibility to hire who my daughter and I want. I will be honest I have hired and fired family members. But I feel it is very important that we have that ability.
3. The last time the regulations were approved it made things harder for my family. One reason is the extra expense it cost to hire an employee. The classes that have to be taken (CPR) having to pay again for back ground checks and the drug testing. Also the application for providing services is horrible to try to fill out. I still don't understand why some providers could not have been grandfathered in. I also don't understand why a provider has to pay twice for everything if they want to provide services for more that one consumer. Even for someone providing respite.
4. I feel it would also be beneficial if agencies had a list of CLS workers and respite workers that they could give to families.
5. Also the regulation that says you can’t have case management and services provided by the same agency is difficult when there are not many in your area. Before you could fill out an exception. Now you can only have a exception if the services are not offered within a 30 mile radius. Where we live that is difficult.
6. I have heard that the ADT programs are also changing. I would like to ask how they are going to change? Wanting to get consumers out into the community more is a great idea, but when you have to take 5 or 6 out at a time it is not always the best scenario. My daughter loves to volunteer but I don't think they would let her do that if a agency has to take groups.
7. Places of employment here in our area is very limited. Not all clients are going to be able to work a part time job. Some can learn their job but for safety reasons can not be left at a job alone. I would like to see agencies have the flexibility to go and stay with a consumer at a job for the amount of time they are to be there. It is no different than taking them out into the community.”

(b) Response: Regarding point #3, the employee requirements under the participant-directed services (PDS) option are related specifically to each participant for whom they are employed. Certain requirements may be transferred, if not expired, with employment to another PDS recipient. Transferable requirements include the tuberculosis (TB) screening, CPR/ First Aid certification, and College of Direct Supports training. All other requirements are unable to be transferred to another PDS recipient as they are time sensitive and must be completed prior to employment.

Regarding point #4, this is an option that could be discussed between families and providers.

Regarding point #5, the requirement for conflict free case management is a federal requirement from the Centers for Medicaid Services (CMS). CMS issued a final regulation for all 1915 (c) waivers which can be found here: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-SupportS/Home-and-Community-Based-Services/Home-and-Community-Based-Services.html.

Regarding point #6, the regulation filed did not make any changes to the day training service. The SCL regulation does not require day training programs to take people out into the community in groups. To the contrary, day training services are required to be person centered.

Regarding point #7, there is no requirement in the SCL regulation that all participants must work. The regulation states: "the expectation shall be for systemic fading of the supported employment specialist to begin as soon as possible without jeopardizing the job."

The regulation also states that long term supports may be provided until the "supported employment specialist is no longer needed on a regular basis." The intention is not to remove needed support but rather to ensure the appropriate support is provided to the participant. If the person has needs related more to personal safety than to employment then the participant's person centered team may consider which other services may be most useful according to the specific needs of the individual. Some services that may be considered could be personal assistance or residential services.

(a) Comment: Jean M Russell, Vice President, Developmental Services, Seven Counties Services, stated the following:

"Page 64 Section 6 There is lack of clarity regarding Conflict Free Case Management and a consumer electing PDS. If a consumer selects PDS then this consumer should be allowed to select any provider they choose even if that includes selecting a support broker and other services from the same entity. Need this clarified."

(b) Response: The SCL regulation does not preclude a participant's choice of case manager but rather only requires that case management be conflict-free as mandated by CMS.

An exemption is possible if the provider is the only willing and qualified SCL provider within 30 miles of the participant's residence as evidenced by documentation of the lack of willing and qualified providers. As noted, the requirement for conflict free case management is a federal requirement imposed by CMS. CMS issued a final regulation for all 1915 (c) waivers which can be found here: http://www.medicaid.gov/Medicaid-

CHIP-Program-Information/By-Topics/Long-Term-Services-and-SupportS/Home-and-Community-Based-Services/Home-and-Community-Based-Services.html.

(a) Comment: Jean M Russell, Vice President, Developmental Services, Seven Counties Services, stated the following:

"Page 64 Section 6 There also needs to be clarification regarding case management entities seeking to provide services as a Support Broker under PDS. If an agency agrees to provide this service they should also be required to provide the Financial Management Services. There is not any regulation to prohibit any agency to perform the functions of an FMA. Therefore, it is not appropriate to mandate existing FMA providers to provide this service to a separate entity. There is a significant cash flow impact on FMA agencies as well as claim issues that put the separate FMA provider at risk with little or no venue for recouping funds expended that ultimately are not reimbursed by Medicaid. It is requested the state stop mandating existing FMA providers to perform this function for outside providers.

It is unfair and unduly burdensome to the Community Mental Health Centers and the AAA's to have to perform that function for a separate entity. There's significant cash flow issues related to paying employees and then being paid by Medicaid, as well as any errors that end up happening that result in having paid employees. There is not a Community Mental Health Center and I'm confident a AAA that has ever gone back to a paid employee on behalf of a consumer and said we've now lost that money and are not going to get reimbursed for it; so, you need to give it back to us. So, it is unfair to mandate that the Community Mental Health Centers and the AAA's perform this service."

(b) Response: The SCL program does not have a support broker service. Case management is a traditional service that is required for any participant receiving SCL funding. The conflict free requirement reflects federal requirements.

(a) Comment: Steven Shannon, Executive Director, Kentucky Association of Regional Programs, Inc. made the following comment:

"Section 6 delineates the case manager requirements. It is recommended that this section include an access standard beyond be telephone access standard. The access standard should include case managers' primary office should be within a clear mileage or travel time from either the participant's home or day program. For example, case managers could be required to have a primary office within 45 miles or 45 minutes of the participant's home or day program."

(b) Response: The Department for Medicaid Services (DMS) made a decision to have common case management standards across the waivers. This was in response to requests for consistency. A case manager is required to provide a participant and the participant's team members twenty-four (24) hour telephone access to a case management staff person.

(a) Comment: Steven Shannon, Executive Director, Kentucky Association of Regional Programs, Inc. made the following comment:

“Also, Section 6 includes responsibilities case managers have for participants opting for participant directed services. Section 6. (4) (e) b. (ii) indicates the case management shall include “Assisting the participant in recruiting and managing employees; and.” This language may cause some participants selecting the participant directed services and their respective employees to conclude the case manager is the employer. Therefore, it is recommended either this language be omitted or clarifying language is included to clearly specify assisting with employees hired by the participant.

Amended language to this section may include the following to further clarify that the case management agency is not the employer while ensuring the participant is provided strategies to for recruiting and managing employees.

“Assisting the participant in identifying strategies for recruiting and managing employees; and.”

(b) Response: Thank you for your suggestion. DMS will file an “amended after comments” regulation to adopt the recommendation. The revised language will read as follows:

“(ii) Assisting the participant in identifying strategies for recruiting and managing employees; and.”

(a) Comment: Jodi Wilson, Regional Director of ResCare, made the following comment:

“There is great imbalance, in my opinion, that seems to exist in many places with regards to exactly what Conflict Free Case Management means and how this is to be consistently and fairly applied. I think there should be more guidance given in this area as often Residential providers become victim to Case Manager whims, directives, and expectations that are not necessarily those of the team.”

(b) Response: Conflict-free case management is defined in the regulation as follows:

“Conflict free case management shall be a scenario in which a provider including any subsidiary, partnership, not-for-profit, or for-profit business entity that has a business interest in the provider who renders case management to a participant shall not also provide another 1915(c) home and community based waiver service to that same participant unless the provider is the only willing and qualified SCL provider within thirty (30) miles of the participant’s residence.”

The cabinet continues to train case managers across the state regarding case management standards and is available to provide technical assistance.

(a) Comment: Shannon McCracken, Interim Executive Director, Kentucky Association of Private Providers; Brittany Knoth, Executive Director Path Forward of KY; Robert J. Illback, PsyD, ABPP, President and Chief Executive Officer of REACH of Louisville; Stephen S. Zaricki, MSW, Executive Director Community Living, Inc.; David Coons Family Home Provider; Meghen Wilson Growing Minds Learning Center; Jenifer C. Frommeyer, Executive Director Dreams With Wings; Leah F. Campbell, JD, Chief Operating Officer Apple Patch Community; Tomika H. Cosby, Executive Director Kentucky Case Management; Steve Frommeyer, Parent of a recipient of waiver services; Leigh Denniston of Almcare; Diane Quarles-Hartman, BS/MHA, Executive Director, Evergreen Life Services; Pamela J. Millay, R.N., J.D, Clinical Director/CPO Redwood; Myra Gribbins, Owner/Executive Director Reach for the stars Case Management; and Brad Schneider Vice President, Developmental Services Division LifeSkills, Inc. stated the following:

"In 2013 KAPP commented: While we acknowledge the conflict---free case management model requirement in the new waiver, the need to ensure freedom of choice is greater than ever. We expressed at the time that the decision to require conflict---free case management actually limits choice.

We also commented on the Case Management rate reduction: The description of additional responsibilities and the anticipated authoritative role for Case Managers, not to mention increased training requirements, seems to constitute a rate INCREASE or at least maintenance of the rate. Instead, the rate for CM decreased 15%, despite a significant increase in work and responsibility. KAPP predicted this would cause higher caseloads resulting in lower quality services."

(b) Response: Case management is required by CMS (who funds the SCL waiver program) to be conflict free.

The adjustment of the rates was made to better align Kentucky's rates with the national median payment ranges of $100-250.00 per month as reported by the National Association of State Directors of Developmental Disability Services (NASDDDS). Kentucky's rate of $320 per month is well above the national median.

Despite the rate reduction the number of case management providers has increased from 104 in 2012 to 145 – a 39.4% increase.

(a) Comment: Shannon McCracken, Interim Executive Director, Kentucky Association of Private Providers; Brittany Knoth, Executive Director Path Forward of KY; Robert J. Illback, PsyD, ABPP, President and Chief Executive Officer of REACH of Louisville; Stephen S. Zaricki, MSW, Executive Director Community Living, Inc.; David Coons Family Home Provider; Meghen Wilson Growing Minds Learning Center; Jenifer C. Frommeyer, Executive Director Dreams With Wings; Leah F. Campbell, JD, Chief Operating Officer Apple Patch Community; Tomika H. Cosby, Executive Director Kentucky Case Management; Steve Frommeyer, Parent of a recipient of waiver services; Leigh Denniston of Almcare; Diane Quarles-Hartman, BS/MHA, Executive

Director, Evergreen Life Services; Pamela J. Millay, R.N., J.D, Clinical Director/CPO Redwood; Myra Gribbins, Owner/Executive Director Reach for the stars Case Management; and Brad Schneider Vice President, Developmental Services Division LifeSkills, Inc. stated the following:

"KAPP's requests for the past 2 years have been restore the case management rate (in light of the ADDITIONAL responsibilities placed upon them through the CMS Final Rule requirements) and to rework or remove the Focus Tool, as it is NOT person---centered. It is a standardized form that has become redundant and ineffective.

Some negative realities of conflict---free case management under the Kentucky model has been the authoritative nature in which case managers seem to operate as reviewers. They seem to misunderstand their role as the team lead in a collaborative process and instead see themselves as an extension of DBHDID or Guardianship.

Some service agencies have found they are required to coordinate care, send frequent reminders to Case Managers (CM) for needed documents, include them in follow up to incidents, and send requested documents to CM rather than the CM visiting with the person and reviewing the necessary documents at that time. None of the residential or DT time spent on case coordination is reimbursable.

An unintended consequence of the waiver model seems to have pitted Case Managers and Service Providers against each other, rather than to encourage them to collaborate for the person's best interest and outcomes."

(b) Response: The case manager's role is to advocate for standards that promote outcomes of quality for people in SCL. Case managers are to encourage and advocate for person centered services and supports that are designed to meet the needs of each person. They facilitate the person centered team meetings and communications in order to help ensure appropriate decisions are being made and that appropriate services and supports are in place. All members of a person's team should work collaboratively so people have support to participate in everyday community activities. Agency supervisors should maintain oversight of these efforts and work together for successful outcomes.

(a) Comment: Shannon McCracken, Interim Executive Director, Kentucky Association of Private Providers; Brittany Knoth, Executive Director Path Forward of KY; Robert J. Illback, PsyD, ABPP, President and Chief Executive Officer of REACH of Louisville; Stephen S. Zaricki, MSW, Executive Director Community Living, Inc.; David Coons Family Home Provider; Meghen Wilson Growing Minds Learning Center; Jenifer C. Frommeyer, Executive Director Dreams With Wings; Leah F. Campbell, JD, Chief Operating Officer Apple Patch Community; Tomika H. Cosby, Executive Director Kentucky Case Management; Steve Frommeyer, Parent of a recipient of waiver services; Leigh Denniston of Almcare; Diane Quarles-Hartman, BS/MHA, Executive Director, Evergreen Life Services; Pamela J. Millay, R.N., J.D, Clinical Director/CPO Redwood; Myra Gribbins, Owner/Executive Director Reach for the stars Case

Management; and Brad Schneider Vice President, Developmental Services Division LifeSkills, Inc. stated the following:

"Case Managers should NOT bear the responsibility of negotiating rates of pay for additional staffing between the service provider and DBHDID staff. The process is inappropriate and unrealistic."

(b) Response: The role of the person centered team is to determine the best course of action for the person being supported. Person centered planning enhances a person's quality of life while putting the person into the expert role over their own life. This expert role allows for increased self-determination because it increases choices in areas such as types of living arrangements, type of employment, models of therapeutic interventions and leisure activities. Person centered planning uses self-determination and inclusion to promote human dignity and worth, and satisfaction with quality of life. It is the responsibility of each team member to advocate for the individual, influence decisions about documentation, make recommendations, and implement the plan. The movement from a hierarchical model of team functioning to what is essentially a cross-functional model, is not easy, and places challenges with great opportunities for significant success. One of the challenges in this process is to provide the case manager with the information necessary so that the case manager who facilitates the exceptional support process can adequately negotiate the terms of the exceptional support request. The concept of conflict free case management provides the back-drop for this process.

(a) Comment: Lisa A. (Chaplin) Wise, BS Special Edu, Assistant Director Communicare made the following comment:

"Section 6 Case Management Requirements, If the participant's true Freedom of Choice is to keep a Case Manager that they have been with for several years, how can conflict free be their true choice if they are required to transition to a case manger that they have never met?"

(b) Response: The SCL regulation does not preclude a participant's choice of case manager. It only requires that case management be conflict-free. An exemption is possible if the provider is the only willing and qualified SCL provider within 30 miles of the participant's residence as evidenced by documentation of the lack of willing and qualified providers. The requirement for conflict free case management is a federal requirement from CMS. CMS issued a final regulation for all 1915 (c) waivers which can be found here:

http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-SupportS/Home-and-Community-Based-Services/Home-and-Community-Based-Services.html

Participants also have the option of keeping their current case manager and finding alternative service providers.

(a) Comment: Maria Alagia Cull, ResCare made the following comment:

“ResCare appreciates that CMS requires conflict-free case management. Section 1 defines a case manager as an individual who works closely with a paiiicipant to ensure he/she has a person-centered service plan that focuses on the participant's ongoing expectations and satisfaction with his/her life and maintains the freedom of choice of providers in a conflict-free climate. Section 6 of the regulation details the requirements for case management.

"Conflict-free" is a situation in which the provider of case management is not to provide another waiver service to the same participant, unless certain circumstances exist. While this restriction is designed to protect against overutilization or inappropriate utilization of services, it fails to recognize the fact that many case managers are now employed by multiple organizations for different services and are able to sklli the intention of the law by following the letter of the law. Additional language should be added that a case manager is prohibited from referring to an entity or service with which it has a contractual or business relationship.”

(b) Response: This prohibition exists within the definition of conflict free case management. Conflict free case management is defined as a scenario in which a provider including any subsidiary, partnership, not-for-profit, or for-profit business entity that has a business interest in the provider who renders case management to a participant shall not also provide another 1915(c) home and community based waiver service to that same participant unless the provider is the only willing and qualified SCL provider within thirty (30) miles of the participant’s residence as evidenced by documentation of the lack of willing and qualified providers.

(a) Comment: Maria Alagia Cull, ResCare made the following comment:

“Section 6 also sets forth the duties of a case manager which includes language that the case manager is accountable to the participant, the participant's certain person-centered team and the case manager's employer. Subsection 4 sets forth the items that a case management service is to provide which includes, among other things, initiating, coordinating, implementing, monitoring, etc. a person centered plan, assisting a participant, facilitating person-centered team meetings and a monthly face-to-face contact with the participant. Additional language should be added to require collaboration and coordination as well as personal and virtual communication with the person-centered team and the timely sharing of documents. Case managers should be held accountable for their failure to provide services in a timely and accurate manner which could include monetary recourse by providers unable to bill for services or suspension from the program due to a case manager's failure to complete accurate and timely replies. Providers should not have to use an attorney to force a case manager to perform his/her duties.

(b) Response: All waiver providers are monitored by the department to ensure

regulatory compliance. All providers are expected to collaborate as a team in the best interest of the persons supported.

(2) Subject: Direct Support Professional Supervisor Requirements

(a) Comment: Johnny Callebs, Regional/Executive Director of Independent Opportunities – Richmond, stated the following:

“Direct Support Professional Supervisor: two years of experience should be changed to one year. Please remove the requirement for supervisory training curriculum approved by the department and allow agencies to provide on the job training and mentoring.”

(b) Response: The requirements for direct support professional supervisor were not changed in this regulation. Provider agencies are encouraged to provide on the job training in addition to the required supervisory training.

(3) Subject: Supported Employment

(a) Comment: Johnny Callebs, Regional/Executive Director of Independent Opportunities – Richmond, stated the following regarding supported employment specialist requirements:

“Please remove the bachelor’s degree and one year experience requirements. The service has been successfully provided for many years by non-degreed staff. A credential is not necessary. The Kentucky Supported Employment Training Project curriculum from the Human Development Institute at the University of Kentucky is sufficient.”

Jean M Russell, Vice President, Developmental Services, Seven Counties Services, stated the following:

“Page 65 Section C -1/C-3, We acknowledge that all SE Specialists have to complete the Kentucky Supported Employment Training Project Curriculum; however, is it correct that only a non-degreed person with only 1-year experience is required to be credentialed by the Department? Request that the SE Training Project Curriculum be sufficient and the Credentialing requirement be optional, not required for SE Specialists. For Kentucky to sincerely comply with the CMS Rule in the next 4 years, the barriers to true Supported Employment for everyone must be removed and this includes the barrier to ensuring qualified staff.”

“Shannon McCracken, Interim Executive Director, Kentucky Association of Private Providers; Brittany Knoth, Executive Director Path Forward of KY;
Robert J. Illback, PsyD, ABPP, President and Chief Executive Officer of REACH of Louisville; Stephen S. Zaricki, MSW, Executive Director Community Living, Inc.;
David Coons Family Home Provider; Meghen Wilson Growing Minds Learning Center;
Jenifer C. Frommeyer, Executive Director Dreams With Wings; Leah F. Campbell, JD, Chief Operating Officer Apple Patch Community; Tomika H. Cosby, Executive Director

Kentucky Case Management; Steve Frommeyer, Parent of a recipient of waiver services; Leigh Denniston of Almcare; Diane Quarles-Hartman, BS/MHA, Executive Director, Evergreen Life Services; Pamela J. Millay, R.N., J.D, Clinical Director/CPO Redwood; Myra Gribbins, Owner/Executive Director Reach for the stars Case Management; and Brad Schneider Vice President, Developmental Services Division LifeSkills, Inc. stated the following:

“We request that the SE Training Project Curriculum through HDI at UK be sufficient and the Credentialing requirement be optional, not required for SE Specialists. Please remove the requirement for bachelor’ degree and one year experience. The service has been successfully provided for years by non---degreed staff. For Kentucky to sincerely comply with the CMS Rule in the next 4 years the barriers to true Supported Employment for everyone must be removed and this includes the barrier to ensuring qualified staff.”

(b) Response: The Department for Medicaid Services (DMS) will file an “amended after comments” regulation to remove the following requirements from the supported employment specialist requirements:

“(b)1. Has at least a bachelor’s degree from an accredited college or university and one (1) year of experience in the field of developmental disabilities;

(d) Sequentially completes the Kentucky Supported Employment Training Project curriculum from the Human Development Institute at the University of Kentucky within eight (8).”

Below are all changes as displayed:

"Supported employment specialist" means an individual who:
(a) Provides ongoing support services to eligible participants in supported employment jobs in accordance with Section 4 or 10 of this administrative regulation;
~~(b)1. Has at least a bachelor’s degree from an accredited college or university and one (1) year of experience in the field of developmental disabilities; [or]~~
2. Has previously qualified or been credentialed by the department to provide supported employment services prior to the effective date of this administrative regulation; or
3.a. Has at least one (1) year of [~~Has relevant~~] experience in the field of intellectual or developmental disabilities; and
b. Has completed a department [required training program]approved credential within one (1) year of application while providing supported employment services under the direct supervision of a supported employment specialist [~~or credentialing that substitutes for the educational requirement stated in subparagraph 1. of this paragraph on a year-for-year basis~~]; [and]
(c) Meets the personnel and training requirements established in Section 3 of this administrative regulation[~~; and~~
~~(d) Sequentially completes the Kentucky Supported Employment Training Project curriculum from the Human Development Institute at the University of Kentucky within~~

~~eight (8) [six (6)] months of the date~~ of employment ~~as an employment [the] specialist [begins providing SCL supported employment services]~~.

The following is how the final version of the definition will appear after all changes have been incorporated:

“(99) "Supported employment specialist" means an individual who:
(a) Provides ongoing support services to eligible participants in supported employment jobs in accordance with Section 4 or 10 of this administrative regulation;
(b)1. Has previously qualified or been credentialed by the department to provide supported employment services prior to the effective date of this administrative regulation; or
2.a. Has at least one (1) year of experience in the field of intellectual or developmental disabilities; and
b. Has completed a department required training program within one (1) year of application while providing supported employment services under the direct supervision of a supported employment specialist ; and
(c) Meets the personnel and training requirements established in Section 3 of this administrative regulation.”

(a) Comment: Jean M Russell, Vice President, Developmental Services, Seven Counties Services, stated the following:

“Page 65 Section C-1/C-3, Request that the “minimum of 5 years of experience in the field of intellectual or developmental disability” be lowered to 2-3 and/or the field be broadened to “human services.”

(b) Response: As a result of the amendments addressed in the prior response only one year of experience will be required.

(a) Comment: Shannon McCracken, Interim Executive Director, Kentucky Association of Private Providers; Brittany Knoth, Executive Director Path Forward of KY;
Robert J. Illback, PsyD, ABPP, President and Chief Executive Officer of REACH of Louisville; Stephen S. Zaricki, MSW, Executive Director Community Living, Inc.;
David Coons Family Home Provider; Meghen Wilson Growing Minds Learning Center;
Jenifer C. Frommeyer, Executive Director Dreams With Wings; Leah F. Campbell, JD, Chief Operating Officer Apple Patch Community; Tomika H. Cosby, Executive Director Kentucky Case Management; Steve Frommeyer, Parent of a recipient of waiver services; Leigh Denniston of Almcare; Diane Quarles-Hartman, BS/MHA, Executive Director, Evergreen Life Services; Pamela J. Millay, R.N., J.D, Clinical Director/CPO Redwood; Myra Gribbins, Owner/Executive Director Reach for the stars Case Management; and Brad Schneider Vice President, Developmental Services Division LifeSkills, Inc. stated the following:

“Current regulation states: Has relevant experience or credentialing that substitutes for the educational requirement stated in subparagraph 1 of this paragraph on a year---for-

--year basis; The proposed changes state: Has at least 1 year of prior experience in the field of intellectual or developmental disability and the completion of a department approved credential within 1 year of application, while providing supported employment services under the direct supervision of a qualified employment specialist; Comment: The allowance for the employee to work for 1 year under supervision, while completing the credentialing process is a positive change."

(b) Response: Thank you for your comment.

(a) Comment: Lisa A. (Chaplin) Wise, BS Special Edu, Assistant Director Communicare made the following comment:

"Section 1 Definitions Supported Employment specialist, Will HDI be offering more frequent course work or accommodations to be able to meet this training requirement?"

(b) Response: The required training will be offered no less than three times per year.

(a) Comment: Johnny Callebs, Regional/Executive Director Independent Opportunities-Richmond, made the following comment:

"Please increase the twenty-four units of SE each month. This is only six hours a month and few employers want to hire someone for so few hours."

"Shannon McCracken, Interim Executive Director, Kentucky Association of Private Providers; Brittany Knoth, Executive Director Path Forward of KY;
Robert J. Illback, PsyD, ABPP, President and Chief Executive Officer of REACH of Louisville; Stephen S. Zaricki, MSW, Executive Director Community Living, Inc.;
David Coons Family Home Provider; Meghen Wilson Growing Minds Learning Center; Jenifer C. Frommeyer, Executive Director Dreams With Wings; Leah F. Campbell, JD, Chief Operating Officer Apple Patch Community; Tomika H. Cosby, Executive Director Kentucky Case Management; Steve Frommeyer, Parent of a recipient of waiver services; Leigh Denniston of Almcare; Diane Quarles-Hartman, BS/MHA, Executive Director, Evergreen Life Services; Pamela J. Millay, R.N., J.D, Clinical Director/CPO Redwood; Myra Gribbins, Owner/Executive Director Reach for the stars Case Management; and Brad Schneider Vice President, Developmental Services Division LifeSkills, Inc. stated the following:

"We request to increase the twenty-four units of SE each month to a customized and realistic number. This is only 6 hours per month and few employers want to hire someone for so few hours."

(b) Response: This requirement does not restrict the number of hours a participant can work. Supported employment is intended to help people with disabilities work in the community with as little paid staff assistance as is possible. Their goal should be to maximize the amount of time they are working in the community without staff assistance.

Supported employment is a person-centered support. This means that the actual needs of the person determine the amount and configuration of the supports that are necessary for the person to live their life as independently as is possible.

The amount of support to be provided is defined by and justified in the Long-Term Employment Support Plan. The person working in the community may receive the amount of support that is justified in the plan. They are not limited to six hours per month.

In every Long Term Employment Support Plan there is the expectation that the person will be working toward increased independence. For that reason a fading plan is required.

Six hours per month (24 units) is the minimum amount of supported employment that a person working in the community should receive.

These supported employment units should be used to monitor the person's work situation and address workplace situations before they have the opportunity to threaten the person's employment.

These units should not be used to provide one on one support in the workplace unless it is necessary and justified in the Long-Term Employment Support Plan.

If a person's opportunity to work is limited to the minimum allowable amount of supported employment (six hours per month) the support is not person centered. It is defined purely by the number of units that the provider may be approved for payment.

(a) Comment: Karen Gardner, of Tri-Generations, made the following comment:

"Supported employment is a must in order to meet CMS Final Rules and move forth for community inclusion for folks. Since the new SE definition has gone into effect we have had fewer folks enter this service and have had some who have left their jobs because long term support is required plus some simply are not getting adequate supports approved. This service in the waiver is also described as an "impact service". This service is not supporting the very folks this waiver was written for.

Suggestions:
1) Supported Employment needs a billable long term support component that can be provided at a lower rate.
2) The requirement for a degreed staff is a barrier. These supports can have quality outcomes and still be provided by non-degreed staff. SE staff have intense additional training already required, the degree requirement is a barrier not a need."

(b) Response: The Department for Medicaid Services (DMS) will file an "amended after comments" regulation to remove the following requirements from the supported

employment specialist requirements:

“(b)1. Has at least a bachelor’s degree from an accredited college or university and one (1) year of experience in the field of developmental disabilities;

(d) Sequentially completes the Kentucky Supported Employment Training Project curriculum from the Human Development Institute at the University of Kentucky within eight (8).”

Below are all changes as displayed:

"Supported employment specialist" means an individual who:
(a) Provides ongoing support services to eligible participants in supported employment jobs in accordance with Section 4 or 10 of this administrative regulation;
~~(b)1. Has at least a bachelor’s degree from an accredited college or university and one (1) year of experience in the field of developmental disabilities; [or]~~
2. Has previously qualified or been credentialed by the department to provide supported employment services prior to the effective date of this administrative regulation; or
3.a. Has at least one (1) year of [~~Has relevant~~] experience in the field of intellectual or developmental disabilities; and
b. Has completed a department [required training program]approved credential within one (1) year of application while providing supported employment services under the direct supervision of a supported employment specialist [~~or credentialing that substitutes for the educational requirement stated in subparagraph 1. of this paragraph on a year-for-year basis~~]; [and]
(c) Meets the personnel and training requirements established in Section 3 of this administrative regulation~~; and~~
~~(d) Sequentially completes the Kentucky Supported Employment Training Project curriculum from the Human Development Institute at the University of Kentucky within eight (8) [six (6)] months of the date of employment as an employment [the] specialist [begins providing SCL supported employment services]~~.

The following is how the final version of the definition will appear after all changes have been incorporated:

“(99) "Supported employment specialist" means an individual who:
(a) Provides ongoing support services to eligible participants in supported employment jobs in accordance with Section 4 or 10 of this administrative regulation;
(b)1. Has previously qualified or been credentialed by the department to provide supported employment services prior to the effective date of this administrative regulation; or
2.a. Has at least one (1) year of experience in the field of intellectual or developmental disabilities; and
b. Has completed a department required training program within one (1) year of application while providing supported employment services under the direct supervision of a supported employment specialist ; and

(c) Meets the personnel and training requirements established in Section 3 of this administrative regulation."

(a) Comment: Jean M Russell, Vice President, Developmental Services, Seven Counties Services, stated the following:

"Request that the term "impact service" be removed from regulatory language for Supported Employment. It causes the service to be discriminatory to only those participants who can and desire to work independently. Not every person in the SCL waiver can or wants to do that, leaving their ONLY options for a "meaningful day"…an underfunded, overcrowded, understaffed Day Training model OR worse, sitting at home. For Kentucky to sincerely comply with the CMS Rule in the next 4 years, the barriers to true Supported Employment for everyone must be removed."

(b) Response: Long term support for job related tasks is available based upon documented need. If an employee requires long term support for other than job related support, personal assistance or residential staff may be a resource.

(a) Comment: Melissa Renn Brown, Executive Director/Program Director, SCL and MPW Waiver Services, Down Syndrome of Louisville, Inc. stated the following:

"Section 4 (4) (n) Page 62 If CA service notes are required to be uploaded to MWMA then all the services should be the same."

Melissa Renn Brown, Executive Director/Program Director, SCL and MPW Waiver Services, Down Syndrome of Louisville, Inc. stated the following:

"Section 4 (22) (c) 2 a. Page 109 If no other services are entered into MWMA it is not necessary for the the SE LTS Plan to be entered."

(b) Response: The next release includes the ability to record service notes for every service within MWMA. DMS is filing an "amended after comments" regulation that adds the MWMA requirement for other services.

(a) Comment: Shannon McCracken, Interim Executive Director, Kentucky Association of Private Providers; Brittany Knoth, Executive Director Path Forward of KY; Robert J. Illback, PsyD, ABPP, President and Chief Executive Officer of REACH of Louisville; Stephen S. Zaricki, MSW, Executive Director Community Living, Inc.; David Coons Family Home Provider; Meghen Wilson Growing Minds Learning Center; Jenifer C. Frommeyer, Executive Director Dreams With Wings; Leah F. Campbell, JD, Chief Operating Officer Apple Patch Community; Tomika H. Cosby, Executive Director Kentucky Case Management; Steve Frommeyer, Parent of a recipient of waiver services; Leigh Denniston of Almcare; Diane Quarles-Hartman, BS/MHA, Executive Director, Evergreen Life Services; Pamela J. Millay, R.N., J.D, Clinical Director/CPO Redwood; Myra Gribbins, Owner/Executive Director Reach for the stars Case Management; and Brad Schneider Vice President, Developmental Services Division

LifeSkills, Inc. stated the following:

"We request that there is an allowance and realistic understanding for on-going supported employment for someone who may always require supports in order to maintain his/her job. It may be funded lower than the typical SE rate, but higher than the Day Training rate, which only reimburses the provider $8.80 per hour. That is an insufficient rate for any 1:1 service. If sufficiently justified in the participant's service plan, this support should be approved for 1 year without further question. If the person has a job regardless of requiring ongoing support, neither they nor the team should have to justify that every 3-6 months. It is not a failure to have a disability or need ongoing supports in a long-term supports and services waiver."

(b) Response: An allowance for on-going supported employment for persons who need to work in the community already exists.

Supported employment is a person-centered support. This means that the actual needs of the person determine the amount and configuration of the supports that are necessary for the person to live their life as independently as is possible.

The amount of support to be provided is defined by and justified in the Long-Term Employment Support Plan. The person working in the community may receive the amount of support that is justified in the plan. They are not limited to six hours per month.

In every Long Term Employment Support Plan there is the expectation that the person will be working toward increased independence. For that reason a fading plan is required.

The referenced rate of $8.80 per hour only applies when additional supports in the workplace are not justified in the long-term employment support plan.

The protocol for supported employment is as follows:

- Participants receive the amount of support that they need to maintain their employment; but nothing beyond what is needed. The needed support may be comprised of a number of SCL services.
- People needing assistance completing the specific tasks that they have been hired to complete should receive supported employment services as defined in their Long-Term Employment Support Plan (LTESP). There should be a fading plan included in the LTESP to assist the consumer to work toward independence.
- People needing direct assistance due to personal care, behavioral, or medical needs including transportation (that cannot be provided using other Medicaid funded means) that are documented by the support team as being an ongoing current need of the consumer should receive personal assistance if they live in their own residence or with their own family (not a family home provider).
- If they receive residential services, including adult foster care (AFC) or family home provider (FHP), this function is part of the definition of residential services. The fact

that the residential provider's contract with an AFC or FHP does not include this type of transportation is immaterial. The residential provider must acquire the transportation by other means.

- People needing assistance because "something might happen" at the request of the consumer's family or guardian or at the request of the employer should receive day training services. Typically the provision of services in this situation indicates a poor job match and, if the consumer wishes, should be replaced with a better matched job. The delivery of services under these circumstances is also contrary to the goals of the program, which are to help people live their lives as part of the community.

All people receiving waiver services in the community should receive at least six hours of supported employment in order to maintain their employment.

(a) Comment: Shannon McCracken, Interim Executive Director, Kentucky Association of Private Providers; Brittany Knoth, Executive Director Path Forward of KY; Robert J. Illback, PsyD, ABPP, President and Chief Executive Officer of REACH of Louisville; Stephen S. Zaricki, MSW, Executive Director Community Living, Inc.; David Coons Family Home Provider; Meghen Wilson Growing Minds Learning Center; Jenifer C. Frommeyer, Executive Director Dreams With Wings; Leah F. Campbell, JD, Chief Operating Officer Apple Patch Community; Tomika H. Cosby, Executive Director Kentucky Case Management; Steve Frommeyer, Parent of a recipient of waiver services; Leigh Denniston of Almcare; Diane Quarles-Hartman, BS/MHA, Executive Director, Evergreen Life Services; Pamela J. Millay, R.N., J.D, Clinical Director/CPO Redwood; Myra Gribbins, Owner/Executive Director Reach for the stars Case Management; and Brad Schneider Vice President, Developmental Services Division LifeSkills, Inc. stated the following:

"Supported Employment is a must in order to meet the CMS Final Rule and move forward with community inclusion. The new SE definition adding "any hours of paid community employment" to the 16---hour total per day limit. If a participant is working in the community and during that time they are not receiving supported employment services billed through the waiver that time should not be taken away from their potential service time while they are not working that day."

(b) Response: Previous versions of the SCL regulation incorrectly referenced the receipt of supported employment services within both the 16 hour per day and 40 hour per week limit. The revised SCL regulation corrects that error.

The combination of adult day training, community access, and the hours the person works in the community should not exceed 16 hours per day.

The combination of adult day training and the hours the person works in the community should not exceed 40 hours per week.

This allows persons receiving waiver supports to have un-programmed time for rest and relaxation.

(a) Comment: Shannon McCracken, Interim Executive Director, Kentucky Association of Private Providers; Brittany Knoth, Executive Director Path Forward of KY; Robert J. Illback, PsyD, ABPP, President and Chief Executive Officer of REACH of Louisville; Stephen S. Zaricki, MSW, Executive Director Community Living, Inc.; David Coons Family Home Provider; Meghen Wilson Growing Minds Learning Center; Jenifer C. Frommeyer, Executive Director Dreams With Wings; Leah F. Campbell, JD, Chief Operating Officer Apple Patch Community; Tomika H. Cosby, Executive Director Kentucky Case Management; Steve Frommeyer, Parent of a recipient of waiver services; Leigh Denniston of Almcare; Diane Quarles-Hartman, BS/MHA, Executive Director, Evergreen Life Services; Pamela J. Millay, R.N., J.D, Clinical Director/CPO Redwood; Myra Gribbins, Owner/Executive Director Reach for the stars Case Management; and Brad Schneider Vice President, Developmental Services Division LifeSkills, Inc. stated the following:

"In 2013, KAPP testified at a public hearing for this Supports for Community Living waiver prior to its implementation. At that time we expressed our considerable concern, as professionals in this field with decades of experience providing quality supports to Kentucky's citizens with I/DD.

The Commissioner of DBHDID at that time, Stephen Hall, promised in an email to providers that he had "listened to people with disabilities of all ages, their family members, those who are paid with taxpayer dollars to provide services and those who advocate to improve Kentucky's individualized supports." He went on to say that we want "these most vulnerable citizens to have good evidenced based services to improve their lives." He concluded this email by saying, "while not perfect, this can be a giant step forward for Kentucky citizens with developmental and intellectual disabilities and their families."

KAPP believes that was a sincere message and we do support the mission and intent of the waiver, as well as the CMS Final Rule, ADA and Olmstead Act. That being said, providers do not feel that we've been heard. We predicted in 2013 the specific reasons why the waiver contained insurmountable barriers to success for participants. Since that time, we have offered suggestions and solutions on a regular basis, which we believe would bring us to a successful outcome. We are not talking about success for providers; we are talking about success for the participants who utilize the waiver. The Department may believe that the failure of the waiver thus far is due to providers' resistance to change. Although any change in the way services are delivered is a challenge, providers have always adapted and risen to the occasion. The reality is, agencies would not refuse to assist participants into needed services. If the assumption were that providers are only concerned with funding, why would we not access the HIGH RATES for the service of Supported Employment and Community Access, and GROW the underfunded, overcrowded and understaffed Day Training model? The only reasonable answer for the condition of the SCL waiver today is that it does not work. We have been offering solutions since 2013 and continue to do so. The barriers to services and the excessive administrative burdens must be removed.

KAPP believes providers have NOT been true stakeholders in the development of the State Transition Plan, required by CMS for compliance with the Final Rule. Kentucky conducted the required forums, but the DBHDID's Quality Assurance staff (which is the entity with direct contact to and providing technical assistance for providers) has not been educated on the rule and could not answer questions or provide guidance on the self---assessment process agencies were issued. The surveys were sent out without an explanation of their significance. Assuming it was another required survey from the division, many Executive Directors delegated the task to program directors or other staff to complete. They did not realize that this would result in their initial classification in the CMS Final Rule process. The majority of providers were classified as NOT being Home & Community Based and subject to the heightened scrutiny process. This was surprising and unsettling for providers. Providers were then given another survey opportunity and have been told these results could change their classifications. Providers anxiously await those results.

The lack of information and collaboration between the state and providers has caused fear and skepticism about the entire process. The only source of information for providers on the CMS Final Rule is an email address at ky.gov. When KAPP has requested information or even a copy of the CMIA letter issued to Kentucky, we received no response. We have found the needed information either from ANCOR or directly from CMS through its website. KAPP requests that Kentucky immediately begin involving and informing providers (and its DBHDID Quality Assurance staff) in order to work together and successfully comply with the Home & Community Based Rule by the required timelines. This process is about the participants we support in the community. Kentucky cannot implement effective change without supporting its provider community to do so.

As for this specific regulation, there have been some modifications since the original draft in 2013 and we appreciate that, however, the top 10 changes we have discussed and advocated for over 2 years, have not been seriously addressed. With the CMS Final Rule now very much a daunting reality for all of us, the success for Kentucky and its citizens with I/DD rides on the future of this waiver.

Throughout KAPP's comments, I will be referencing our original comment in 2013, our proposed solution, what did change and our comment for this specific proposed regulation."

(b) Response: Thank you for your comment. Prior to the submission of the Statewide Transition Plan to CMS there was a 30-day public comment period beginning on November 5, 2014. During this time, providers, participants, and advocacy groups were welcome to submit their comments on Kentucky's process for coming into compliance with the HCBS federal final rules. Many stakeholders did, in fact, provide comments at that time. The Cabinet will be communicating updated compliance categories to providers based on their submitted compliance plan templates in November.

(a) Comment: Shannon McCracken, Interim Executive Director, Kentucky Association of Private Providers; Brittany Knoth, Executive Director Path Forward of KY; Robert J. Illback, PsyD, ABPP, President and Chief Executive Officer of REACH of Louisville; Stephen S. Zaricki, MSW, Executive Director Community Living, Inc.; David Coons Family Home Provider; Meghen Wilson Growing Minds Learning Center; Jenifer C. Frommeyer, Executive Director Dreams With Wings; Leah F. Campbell, JD, Chief Operating Officer Apple Patch Community; Tomika H. Cosby, Executive Director Kentucky Case Management; Steve Frommeyer, Parent of a recipient of waiver services; Leigh Denniston of Almcare; Diane Quarles-Hartman, BS/MHA, Executive Director, Evergreen Life Services; Pamela J. Millay, R.N., J.D, Clinical Director/CPO Redwood; Myra Gribbins, Owner/Executive Director Reach for the stars Case Management; and Brad Schneider Vice President, Developmental Services Division LifeSkills, Inc. stated the following:

"KAPP remains firmly committed to employment for persons who choose to work, as well as to providing opportunities to explore this important life choice and receive support to attain and maintain a job.

In 2013 we commented regarding the education requirement for Supported Employment Specialist: Requiring that Employment Specialist s possess a Bachelor's degree will only hinder the provider community from providing adequate employment services. Staff turnover is already a burden to providers and this requirement will lessen the pool of candidates especially in rural communities.

We also asked: with most individuals likely obtaining or choosing part---time work, how will the cost of their supports during the other hours be absorbed given the proposed changes in Day Training and the initial funding decrease for that service?

The reality is that despite the decrease in Day Training Rate by 12% and the increase in Supported Employment rate, which was the cornerstone of this waiver, by 85%, the participation numbers did NOT reflect the goal of either service. According to a recent Open Records request to the Department for Medicaid Services, when comparing calendar year 2013 to 2014, the number of SCL participants receiving Supported Employment services increased only very slightly by 38 participants from 345 to 383. Comparatively, Adult Day Training/Day Training for the same period, the number of participants GREW from 3,802 to 4,443, and increase of 641 participants. As a consequence, waiver recipients are increasingly being served in understaffed, underfunded and overcrowded day programs.

We have been asking for 2 years that the degreed and credentialing requirements be removed. It would accomplish the goal of getting more people community jobs by removing a major unnecessary barrier. The proposed regulation does reflect minor changes in the requirements for staff, but does not come close to broadening the qualifications to "allow for increased provider participation and use of the services to promote community integration" as the waiver application summary of changes indicated.

The intent of the waiver was obviously to promote the Supported Employment service for participants (85% rate increase) and to lessen the utilization of the Day Training model (15% decrease and elimination of an off---site rate differential.) As evidenced by the data showing that since the implementation of the waiver, Day Training has actually GROWN by 14%. Not only have the people in day training centers stayed there, more people have been forced into the service due to lack of other services, or the difficulty to access them. As KAPP cautioned in 2013, cutting the rate of the service did not eliminate or reduce the need for the service, it only reduced the quality. KAPP also cautioned that making Supported Employment services difficult to obtain and maintain and unnecessarily requiring credentialing and degreed requirements for staff to provide the service, that few participants would enter community employment and few providers would be able to provide the service. This prediction has been realized.

Although NOT the intention of the waiver (on paper it appears to be a compliant and progressive regulation) Kentucky's resistance to remove barriers to the KEY services for a meaningful day and true community access has resulted in fewer choices. Additionally, the cut in the rates by 15% of day programs has resulted in lower quality, higher staff to participant ratios and fewer opportunities for community inclusion."

(b) Response: Although the number of participants in day training has increased, when considering the overall increase in waiver participants and enrollment in day training, the percentage of waiver participants utilizing day training has decreased from 90% in 2013 to 87% in 2015. The number of people utilizing community access is actually increasing – 294 people used this service in 2014 and 355 in 2015.

Since focusing on community employment, the number of people with disabilities in Kentucky who are working in the community has risen from one of the lowest rates in the country to the national average of 18%.

The stated goal for increasing the employment of SCL2 participants canvassed through the National Core Indicators was to increase the number of participants working in the community by 5%. After accounting for uniform (5%) job losses across both Kentucky and the entire nation caused by the economic recession, Kentucky has rebounded to record the targeted 5% increase in the community employment of SCL participants from the post-recession low (2013/14 data).

In regards to employment, since Medicaid is the funder of last resort, 95% of the waiver participants newly entering the workforce will receive employment services through the Office of Vocational Rehabilitation for at least 6 months up to about 24 months before their first waiver prior authorization for employment is requested. This means that only a handful of waiver participants who decided to seek community employment upon entering SCL2 are actually being funded through the waiver. We have attempted to obtain an estimate of the number of "new" VR clients who receive waiver services but that number is not tracked.

While we recognized that our previous process for delivering employment services to waiver participants was flawed, we had no idea exactly how flawed it was until we visited supported employment providers and conducted utilization reviews to determine the efficacy of the supports being provided as supported employment. The result of the utilization review was the recognition that a large percentage of persons receiving supported employment services had actually completely mastered their jobs and were receiving supports 100% of the time due to guardian's requests, an incorrect assessment of the crisis needs of the individual, and a lack of understanding of the requirements of Supported Employment. Recognition of these facts resulted in the conversion of a large number of supported employment prior authorizations to adult day training or personal assistance.

If there is a change in the person's disability or the emergence of a secondary disability that significantly impacts a person's ability to work the person is entitled to receive a second set of services through vocational rehabilitation.

Prior to the implementation of SCL2 this reality was not addressed. When we initiated this process with SCL2, the percentage of requests receiving a second segment of service through OVR went from negligible to around 40%. It has since settled in between 30-35% on average.

When comparing the supported employment rate and the day training rate, even with the increase in the supported employment rate for SCL and the reduction of the adult day training rate, the provider income generated per staff member for adult day training still exceeds the income generated for supported employment.

Supported employment is delivered on a one to one basis and generates $41 per hour of service per staff member.

Even the most conservative estimates place the average staff to participant ratio for adult day treatment at one staff member to five participants. With that ratio adult day training generates $48.40 per hour of service per staff member.

(a) Comment: Lisa A. (Chaplin) Wise, BS Special Edu, Assistant Director Communicare made the following comment:

Section 4 Covered services Supported Employment "Why should the participant's weekly services be limited (penalized because they work in a paid-community job? Please reconsider this weekly service limitation."

(b) Response: Previous versions of the SCL regulation incorrectly referenced the receipt of supported employment services within both the 16 hour per day and 40 hour per week limit. The revised SCL regulation corrects that error.

The combination of adult day training, community access, and the hours the person works in the community should not exceed 16 hours per day.

The combination of adult day training and the hours the person works in the community should not exceed 40 hours per week.

This allows persons receiving waiver supports to have un-programmed time for rest and relaxation.

(4) Subject: Community Access

(a) Comment: Johnny Callebs, Regional/Executive Director of Independent Opportunities – Richmond, stated the following regarding community access specialist requirements:

“A department approved credential is not necessary for a staff member to effectively provide the service. A one time training is sufficient.”

Shannon McCracken, Interim Executive Director, Kentucky Association of Private Providers; Brittany Knoth, Executive Director Path Forward of KY;
Robert J. Illback, PsyD, ABPP, President and Chief Executive Officer of REACH of Louisville; Stephen S. Zaricki, MSW, Executive Director Community Living, Inc.;
David Coons Family Home Provider; Meghen Wilson Growing Minds Learning Center;
Jenifer C. Frommeyer, Executive Director Dreams With Wings; Leah F. Campbell, JD, Chief Operating Officer Apple Patch Community; Tomika H. Cosby, Executive Director Kentucky Case Management; Steve Frommeyer, Parent of a recipient of waiver services; Leigh Denniston of Almcare; Diane Quarles-Hartman, BS/MHA, Executive Director, Evergreen Life Services; Pamela J. Millay, R.N., J.D, Clinical Director/CPO Redwood; Myra Gribbins, Owner/Executive Director Reach for the stars Case Management; and Brad Schneider Vice President, Developmental Services Division LifeSkills, Inc. stated the following:

“The removal of the degreed requirement from the Community Access Specialist is greatly appreciated and allows more opportunities for quality DSP’s to provide quality supports. Additionally, the department--- approved credential is NOT necessary for a staff member to effectively provide the service. A one---time training is sufficient. Comment: For Kentucky to sincerely comply with the CMS Rule in the next 4 years, the barriers to true Community Access for everyone must be removed and this includes the barrier to ensuring qualified staff.”

Melissa Renn Brown, Executive Director/Program Director, SCL and MPW Waiver Services, Down Syndrome of Louisville, Inc. stated the following:

“A Community Access Specialist is now not required to have a Bachelors degree based on the regulation changes. However those that do have a bachelor’s degree, are they be required to complete the credentialing as well as those that do not have a bachelor’s degree?”

(b) Response: DMS will file an “amended after comments” regulation with the Legislative Research Commission to change the requirement from requiring the individual to have completed a “department approved credential” to having completed a “department required training program”.

(a) Comment: Lisa A. (Chaplin) Wise, BS Special Edu, Assistant Director Communicare stated the following comment:

“For those that having been providing community access currently and are not credentialed, would they be considered “previously qualified”?”

(b) Response: Yes, if they have been previously qualified to provide the service.

(a) Comment: Johnny Callebs, Regional/Executive Director Independent Opportunities-Richmond, made the following comment:

“Community Access: Please remove the designation of impact service. For many participants the service cannot be decreased. The requirement for fading will continue to keep many from accessing the service.”

(b) Response: The service is intended to be a bridge to natural community supports. Other services in the SCL waiver can be used for ongoing supports.

“Shannon McCracken, Interim Executive Director, Kentucky Association of Private Providers; Brittany Knoth, Executive Director Path Forward of KY;
Robert J. Illback, PsyD, ABPP, President and Chief Executive Officer of REACH of Louisville; Stephen S. Zaricki, MSW, Executive Director Community Living, Inc.;
David Coons Family Home Provider; Meghen Wilson Growing Minds Learning Center; Jenifer C. Frommeyer, Executive Director Dreams With Wings; Leah F. Campbell, JD, Chief Operating Officer Apple Patch Community; Tomika H. Cosby, Executive Director Kentucky Case Management; Steve Frommeyer, Parent of a recipient of waiver services; Leigh Denniston of Almcare; Diane Quarles-Hartman, BS/MHA, Executive Director, Evergreen Life Services; Pamela J. Millay, R.N., J.D, Clinical Director/CPO Redwood; Myra Gribbins, Owner/Executive Director Reach for the stars Case Management; and Brad Schneider Vice President, Developmental Services Division LifeSkills, Inc. stated the following:

“In theory, Community Access is a great service. It provides an opportunity for individuals who want to be more involved in their respective communities while also developing natural supports to increase their independence. Reality of what we have found is that this service, much like Supported Employment, targets a small percentage of individuals in the SCL waiver. The biggest barriers to success that we have found is not meeting the staffing requirements, it has been meeting the language of the regulations when it comes to Community Access as an impact service. For starters, the service is limited to six (6) month approvals. It is not guaranteed that you will receive an extension of services. Secondly, even with the 6---month approval, it is difficult for

Community Access Specialist to transition persons who need more intense supports to a setting where they are independent with natural supports in such a small time period. Third, the service is not designed to be an alternative to a day program setting, which is what we have seen that the majority of individuals on the SCL waiver have wanted. Most memberships, organizations, and clubs do not meet during the time of 8a--- 4p (normal day program hours). Yet, agencies still receive referrals from Case Managers for Community Access for persons to hold memberships and be active within their community because the person does not want to attend the day program. The choice is either Community Access or Supported Employment to take the place of the traditional 40 hours a week of day program. If you choose to not want seek competitive employment or caught within the red tape of the OVR process, not a candidate to be independent in a community setting with only natural supports due to various reasons, and do not want to attend a day program five days a week, there is nothing else for you. Interesting that the waiver that offers programs to promote inclusion, integration, and choice potentially alienates and segregates people more from their communities (especially if they live in a residential setting). In essence, impact services such as Community Access and Supported Employment services are needed in the waiver, but there is a missing link of services. If the end goal is to promote community inclusion, then there has to be a service that can reach the greater population within the SCL waiver to be a part of their communities rather than only rely on the residential provider to do so in a group setting with two other individuals with disabilities. Again, are we not trying to get away from institutional---type services (i.e. group---based outings)?

Furthermore, with the increased focus on Person Centered Planning and the Service Plan requirements, included in the Summary of Changes must reflect the need for "full access for individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS." It also specifics "individually identified goals and desired outcomes" and to "identify the individual and/or entity responsible for monitoring the plan." KAPP supports the spirit of the CMS rule and Person Centered Planning Processes. These goals apply to everyone in the waiver, not a select few that can qualify for an IMPACT SERVICE. To meet the goals outlined in the CMS rule and moving forward in our 1915c waiver, participants must have access to the service of 1:1 or 1:2 to effectively achieve these goals and outcomes. A case manager can write a wonderful person centered plan, but if a person's only option is an underfunded, overcrowded, understaffed Day Training center, how can the plan be expected to succeed for them? How can 1 staff support up to 10 participants with different support needs to meet their goals? Everyone deserves 1:1 or 1:2 supports, not just a select few that qualify for an IMPACT SERVICE.

Request that the term "impact service" be removed from regulatory language for Community Access. It causes the service to be discriminatory to only those participants who can and desire to live independently. Not every person in the SCL waiver can or wants to do that, leaving their ONLY options for a "meaningful day"…an underfunded, overcrowded, understaffed Day Training model OR worse, sitting at home. For

Kentucky to sincerely comply with the CMS Rule in the next 4 years, the barriers to true Community Access for everyone must be removed."

(b) Response: SCL participants have a wide variety of services available that can be tailored by the person centered team to craft a meaningful day. Community access is available to all waiver participants. It is not necessarily expected that a participant would achieve total independence within a natural setting within six months. However, within the six month prior authorized period, concrete objectives specified in the plan should have been accomplished. If additional supports are needed to advance the person's ultimate outcome, they may be requested through a plan modification.

The expectation is that careful and deliberate person centered planning will result in supports that will result in customized supports tailored to the specific needs and desires of the person involved. This will vary immensely from person to person and may include paid or unpaid supports.

Community access services are designed to enable people to have increased access to community resources and offer opportunities for people to develop personal social networks by building friendships and making connections with other people in their local communities. Impact services, such as community access, are expected to have a significant effect on a person's ability to engage with other people in the local community. Prior authorizations for this service are limited to up to 6 months per request; however, should the person require ongoing community access service beyond a six month prior authorization, the person centered team may request ongoing services based on the person's ongoing need for assistance to connect with community members. The service provision should decrease as the person develops the skills needed to maintain the connection within the community. Other SCL services, such as day training and residential services should be utilized, if needed, when community access services are withdrawn, to assist the person with any additional needs, such as personal care, financial management or transportation.

(a) Comment: Jane Rainey, Mother/Guardian, made the following comment:

"My daughter, Brittany Rainey, is a participant in the Community Access Program. A very competent Community Access Specialist provides Brittany with opportunities within the community that allow her to connect with people who are part of the mainstream population. This has proven to be an excellent experience for Brittany. She relishes the one on one attention from her specialist and she looks forward to participating in activities within the community. However, please understand, Brittany is at her happiest when there happens to be another special needs person at the same class/event. Please, oh please, do not preclude activities where other special needs people are present.

As her parent/guardian I am very pleased to see Brittany have this community exposure. On the other hand, I am highly concerned that the ultimate goal of this program is to expect people within the community to just naturally become involved in

her activities while the Community Specialist fades away. Who will be training the natural supports for clients like my daughter who has a Vagus Nerve Stimulator for seizure control? Who will be training the natural supports to address any of the varying medical needs that are typical of a special needs population?

Expecting a Community Access Specialist to fade into the background and eventually disappear may be appropriate for some special needs people; however, IT IS NOT APPROPRIATE FOR ALL….

That an expected outcome is for Brittany to develop independence and thus reduce the need for the Community Specialist to be present is unrealistic and potentially dangerous. Yes, Brittany can and does manifest behavior that is appropriate in given situations; she is also prone to sudden outbursts when something of little significance goes awry.

Please do not ignore the fact that the term Special Needs reflects a continuum of disabilities. There are those, like my daughter, who benefit significantly by participating in community activities BUT are highly unlikely to develop personal social networks within the mainstream population. Quite frankly, if someone were to seek to befriend Brittany outside of the group in which they were participating, I would question their intentions…

From where I stand, as a parent and guardian, the goals of Community Access need to be tailored more to the needs of the individual: ONE SIZE DOES NOT FIT ALL….

Lastly, where does transportation fit into all this? At one of the meetings I attended recently, it was suggested that ultimately residential will be responsible for transporting individuals to and from their Community Access activities once Community Access services have faded. If an agency the size of Apple Patch, where Brittany attends, has 10 individuals who have faded Community Access services, how can they reasonably be expected to provide transportation for all 10 individuals while still meeting the needs of the individuals who want or need to stay at home?

The benefits of Community Access are numerous. Please keep this program up and running for the purpose of benefiting the special needs population and not for the purpose of reducing costs to the state."

(b) Response: While community access services are intended to occur in an integrated community setting there is no requirement that precludes the presence of other persons with disabilities and there is a provision for community access to be provided to two participants if the participant invites a friend.

Community access is an impact service that is intended to decrease as the participant becomes more independent in accessing and becoming a part of the community. However, that does not mean there is any intention of an SCL participant being left without needed support. It is the responsibility of the person centered planning team to

identify the supports needed for success in the person's community and then identify the most appropriate and effective source of support whether it is natural or paid. For a person with varying medical needs, supervision needs, or a need for behavioral support, if a paid service is needed, residential or personal assistance services could be considered by the team.

Transportation needs should be assessed by the participant's person centered planning team. Options could include but are not limited to natural supports such as carpooling or public transportation or SCL supports such as residential services or personal assistance. Transportation is an included component of each of those services. Transportation is also an available service for individuals who wish to participant direct their services if certain requirements are met.

(a) Comment: Karen Gardner, of Tri-Generations, made the following comment:

"Community Access is a fantastic service and a must in order to meet CMS Final Rules. But the current manner it is being interpreted and implemented is presenting barriers to folks who need long term support. It is described as an "impact service", SCL is a long term support waiver and the current interpretation and implementation of this service as an "impact service" is not supporting the very folks this waiver is written for. The reality of it is that the majority of individuals we support will need our continued support to access the community.

Suggestions:
1) A billable Discovery component to Community Access that would allow the individual to explore their interests and the provider to initially assess interests/needs.
2) A billable Long Term Support Component to Community Access that is reimbursed at a lower rate.
3) The requirement for a degreed staff is a barrier. These supports can have quality outcomes and still be provided by non-degreed staff
4) There also needs to be a service that would help support residential folks to access the community beyond things they would do with their residential staff and housemates. The service needs to be flexible and non-restrictive and have an outcome/goal of nothing more than getting out and enjoying their community."

(b) Response: The degree requirement has been removed. The service is intended to be a bridge to natural community supports. Other services in the SCL waiver can be used for ongoing supports. Community access is available to those who choose residential services. Other opportunities for getting out and enjoying the community are the responsibility of the residential provider.

Thank you for your additional suggestions - they will be reviewed for future waiver amendments.

(a) Comment: Therapeutic Intervention Services, PLLC, made the following comment:

“Section 4.4 Community Access is an impact service much like Supported Employment with the goal of the fading of formal supports for natural supports. This is where the comparisons end. The community Access service would benefit from having the tiered system of discovery, development and analysis and acquisition to ensure a successful transition like in Supported Employment. This structure would minimize the confusion with services being provided that resemble CLS (SCL 1 Service) and Personal Assistance services while supporting the individual through a person-centered process. In my opinion without the step-by-step process, the service is more costly not only to the Cabinet, but also to the individual who may suffer from the lack of a structured service.”

(b) Response: Thank you for your suggestions. DMS is not adopting them at this time but they will be considered for future waiver amendments.

(a) Comment: Therapeutic Intervention Services, PLLC, made the following comment:

“The Cabinet bases its decision to create Community Access based upon these results from the SCL Listening Tour in 2009 when individuals stated they wanted to be more involved in their communities and make friends. It was initially perceived that Community Access would be the solution to the problem of people not feeling connected with their communities. It would help the population in the SCL waiver to established connections in their community. Reality is that Community Access as a service has failed because it continues to be defined as an impact service, which means it is a 1 time-limited service with the goal of lesser reliance of paid formal supports and strengthening of natural supports. What we have found is that Community Access only targets a small population in the SCL waiver. It targets those persons who their team feel can be independent in their community. This is not a person-centered and in fact is a very exclusive service. If a person needs staff assistance or is unable to be left alone due to safety, behavior, and/or medical concerns they are not perceived as a good candidate for Community Access. This further reduces flexibility for a person to make decisions in their life in regards to services. This person who is not considered an ideal Community Access candidate is now limited to day program service, which are segregated in nature, or remaining at home 24 hours a day. There is the option of Personal Assistance, but that is not available for persons receiving Residential Services, which most people in the SCL program are in residential setting. What has happened is that the number of persons utilizing Adult Day Program services has increased while the impact services has not yet taken off.

My Solution is to create a service centered on developing comprehensive community supports and wrapping those community based supports around the individual, similar to the Community Supports Associate in 908 KAR 2:250. This would serve to replace the missing service between Community Access and Day Program. Activities in this service would support independent living and socialization in community locations that address barriers to impede the development of skills necessary for independent functioning in the community resulting in persons being more connected with their communities and developing friendships. In this service, the staff would address the goals identified in the Person Centered Support Plan. This service could be billed under

the HCPCS codes H2021 or H2015, both of which can be currently billed through DBHDID as a Comprehensive Community Supports. This would address the exclusive nature caused by the impact service of Community Access and even help to assist Kentucky with meeting the Final Rule standards set forth by the Federal government for integration into a person's community.

The other option is to simply remove the requirement establishing Community Access as an impact service. If the Cabinet replaced the tiered system of Supported Employment and have the determination of review placed on the Person Centered Team, then the service would be a much more inclusive service because it would take into account the varying functioning levels of each person."

(b) Response: Thank you for your suggestions. DMS is not adopting them at this time but they will be considered for future waiver amendments.

Regarding community access's status as an impact service - it will remain an impact service. It is designed as a bridge to connect and empower a participant to develop networks of natural support and become less reliant on formal supports.

(a) Comment: Shannon McCracken, Interim Executive Director, Kentucky Association of Private Providers; Brittany Knoth, Executive Director Path Forward of KY; Robert J. Illback, PsyD, ABPP, President and Chief Executive Officer of REACH of Louisville; Stephen S. Zaricki, MSW, Executive Director Community Living, Inc.; David Coons Family Home Provider; Meghen Wilson Growing Minds Learning Center; Jenifer C. Frommeyer, Executive Director Dreams With Wings; Leah F. Campbell, JD, Chief Operating Officer Apple Patch Community; Tomika H. Cosby, Executive Director Kentucky Case Management; Steve Frommeyer, Parent of a recipient of waiver services; Leigh Denniston of Almcare; Diane Quarles-Hartman, BS/MHA, Executive Director, Evergreen Life Services; Pamela J. Millay, R.N., J.D, Clinical Director/CPO Redwood; Myra Gribbins, Owner/Executive Director Reach for the stars Case Management; and Brad Schneider Vice President, Developmental Services Division LifeSkills, Inc. stated the following:

"The Community Access service was developed upon the result from the SCL Listening Tour the department conducted in 2009, when individuals who attended stated they wanted to be more involved in their communities and make friends. It was initially perceived that Community Access would be the solution to the problem of people not feeling connected with their communities. Reality is that Community Access as a service has failed because it continues to be defined as an impact service, which means it is a time limited service with the goal of lesser reliance of paid formal supports and strengthening of natural supports. The result has been that Community Access is only a service for a very elite group of participants in the waiver. This is NOT person---centered and in fact is a very exclusive service. If a person needs staff assistance or is unable to be left alone due to safety, behavior and/or medical concerns they are not perceived as a good candidate for CA. This further reduces the flexibility for a person to make decisions in their life in regards to services. Not every person in the SCL waiver

can receive this service, leaving their ONLY options for a “meaningful day”…an underfunded, overcrowded, understaffed Day Training model OR worse, sitting at home. There is the option of Personal Assistance, but that is not available for persons receiving Residential Services, which most people in the SCL program are in residential settings. What has resulted is an increase in Day Training services while impact services have not grown. The other (most simple) option is to simply remove the requirement establishing Community Access as an impact service. As we have confirmed with Medicaid it is not a requirement to include it as a caveat to the service. If the Cabinet replaced the tiered system of Supported Employment and allow the Person Centered Team to determine support needs, then the service would be a much more inclusive and accessible service.”

(b) Response: Community access is available to all waiver participants. It is not necessarily expected that a participant would achieve total independence within a natural setting within six months. However, within the six month prior authorized period, concrete objectives specified in the plan should have been accomplished. If additional supports are needed to advance the person’s ultimate outcome, they may be requested through a plan modification.

The expectation is that careful and deliberate person centered planning will result in supports that will result in customized supports tailored to the specific needs and desires of the person involved. This will vary immensely from person to person and may include paid or unpaid supports.

Community access will remain an impact service. It is designed as a bridge to connect and empower a participant to develop networks of natural support and become less reliant on formal supports. Impact services are not intended as restricted services. Services such as community access are expected to have a significant effect on a person’s ability to engage with other people in the local community. Community access services are designed to enable people to have increased access to community resources and offer opportunities for people to develop personal social networks by building friendships and making connections with other people in their local communities. Impact services, such as community access, are expected to have a significant effect on a person’s ability to engage with other people in the local community.

Prior authorizations for this service are limited to up to six months per request; however, should the person require ongoing community access service beyond a six month prior authorization, the person centered team may request ongoing services based on the person’s ongoing need for assistance to connect with community members.

The service provision should decrease as the person develops the skills needed to maintain the connection within the community. Other SCL services such as day training and residential services should be utilized, if needed, when community access services are withdrawn to assist the person with any additional needs such as personal care, financial management, or transportation.

(a) Comment: Jodi Wilson, Regional Director of ResCare, made the following comment:

“The requirements for Community Access were too stringent and as a result significantly impacted services for many across the state. It is not and should not be used as a replacement service for Day Training but instead alternative for people who are ready for such support. Though the CMS Final Rule requires significant change in this area of service, I don't feel the regulation has done anything to address the needs of those more challenged, whatever the reason. We need to create transition of this service while developing a support/service system that gives ALL the persons in the SCL waiver individualized supports.

(b) Response: Community access was not developed as a replacement for day training. It is not necessarily expected that a participant would achieve total independence within a natural setting within six months. However, within the six month prior authorized period, concrete objectives specified in the plan should have been accomplished. If additional supports are needed to advance the person’s ultimate outcome, they may be requested through a plan modification.

The expectation is that careful and deliberate person centered planning will result in supports that will result in customized supports tailored to the specific needs and desires of the person involved. This will vary immensely from person to person and may include paid or unpaid supports.

Community access services are designed to enable people to have increased access to community resources and offer opportunities for people to develop personal social networks by building friendships and making connections with other people in their local communities. Impact services, such as community access, are expected to have a significant effect on a person’s ability to engage with other people in the local community.

Prior authorizations for this service are limited to up to six months per request; however, should the person require ongoing community access service beyond a six month prior authorization, the person centered team may request ongoing services based on the person’s ongoing need for assistance to connect with community members.

The service provision should decrease as the person develops the skills needed to maintain the connection within the community. Other SCL services such as day training and residential services should be utilized, if needed, when community access services are withdrawn to assist the person with any additional needs such as personal care, financial management, or transportation.

(a) Comment: Jodi Wilson, Regional Director of ResCare, made the following comment:

“The same goes for Supported Employment.”

(b) Response: We agree that supported employment should not be used as a replacement for day training. The goal of the SCL waiver is to help program participants live the same kind of lives that you or I would live, an adult life. Simply put, when you become an adult, you go to work. So in the proper context, adult day training is a replacement for supported employment.

Adult day training should be the exception not the rule. Thirty-two states currently have either a law or an executive order that makes employment in the community the first option for anyone receiving public assistance. Section 511 of the Workforce Innovation and Opportunity Act (WIOA) states that children transitioning from school systems must first conclusively fail at working in the community before they can attend an adult day program or sheltered workshop.

Supported employment, when properly implemented, is among the most person centered supports in the waiver.

(a) Comment: Shannon McCracken, Interim Executive Director, Kentucky Association of Private Providers; Brittany Knoth, Executive Director Path Forward of KY; Robert J. Illback, PsyD, ABPP, President and Chief Executive Officer of REACH of Louisville; Stephen S. Zaricki, MSW, Executive Director Community Living, Inc.; David Coons Family Home Provider; Meghen Wilson Growing Minds Learning Center; Jenifer C. Frommeyer, Executive Director Dreams With Wings; Leah F. Campbell, JD, Chief Operating Officer Apple Patch Community; Tomika H. Cosby, Executive Director Kentucky Case Management; Steve Frommeyer, Parent of a recipient of waiver services; Leigh Denniston of Almcare; Diane Quarles-Hartman, BS/MHA, Executive Director, Evergreen Life Services; Pamela J. Millay, R.N., J.D, Clinical Director/CPO Redwood; Myra Gribbins, Owner/Executive Director Reach for the stars Case Management; and Brad Schneider Vice President, Developmental Services Division LifeSkills, Inc. stated the following:

“Although providers were very excited about the concept of Community Access, especially with the decrease in Day Training rate and total elimination of an off---site day training rate, our concerns initially were the unnecessary degree and credentialing requirements for staff to do this service and also the fact that it was labeled an “impact service.” Impact Service is defined in regulation as “a service designed to decrease the amount of paid supports a participant requires as the participant becomes a) more independent and b) less reliant on an employee. This automatically unfairly disqualifies a large majority of people in the waiver. There is nothing wrong with having neither a disability, nor needing long term supports and services in a long---term supports and services waiver! It’s not a failure if someone continues to need supports, does not become independent and needs to rely on paid supports.

Redistribution of funding from DT services to Community Access services is fundamentally flawed. There is no empirical basis to support the establishment of this time---limited service. There is no incentive for service agencies to even provide this service. The decrease in funding to DT services, which continue to provide on and off---

site supports has affect some providers' ability to implement increased off--- site activities due to the subsequent rise in transportation costs while incurring decreased reimbursement. The rises in cost and the decreases in revenue are unsustainable.

KAPP's suggestion for the past 2 years has been to remove the degreed and credentialing requirements for staff providing Community Access. We also have requested the term "impact service" be removed. Once removed, these barriers would allow providers to increase services and for participants to all be eligible for 1:1 or 1:2 supports in the community. Everyone deserves these supports, not just an elite few. If we truly want congregate Day Training settings to decrease in population, we MUST remove the barriers to allow Community Access! 1:1 and 1:2 supports give the participant the absolute best changes to achieve their outcomes and integrate into their communities.

The belief that 1:1 or 1:2 staff supports for people with significant intellectual disabilities who are receiving Community Access (or Supported Employment) services can be significantly reduced or even faded out completely over time is a dangerous assumption for a significant majority of this population. Participation in Community Access compared to Community Living Supports under SCL1, has plummeted. This reduced participation is a direct consequence of both the aforementioned credentialing issue as well as the difficulty in obtaining approval of person---centered service plans that will allow for the provision of 1:1 staffing for the duration necessary to keep participants actively engaged and most importantly safe.

Although NOT the intention of the waiver, on paper it appears to be a compliant and progressive regulation, Kentucky's resistance to remove barriers to the KEY services for a meaningful day and true community access has resulted in fewer choices. Additionally, the cut in the rates by 15% of those programs has resulted in lower quality, higher staff to participant ratios and fewer opportunities for community inclusion.

(b) Response: Although the number of participants in day training has increased, when considering the overall increase in waiver participants and enrollment in day training the percentage of waiver participants utilizing day training has decreased from 90% in 2013 to 87% in 2015. The number of people utilizing community access is actually increasing – 294 people used this service in 2014 and 355 in 2015.

Since focusing on community employment, the number of people with disabilities in Kentucky who are working in the community has risen from one of the lowest rates in the country to the national average of 18%.

The stated goal for increasing the employment of SCL2 participants canvassed through the National Core Indicators was to increase the number of participants working in the community by 5%. After accounting for uniform (5%) job losses across both Kentucky and the entire nation caused by the economic recession, Kentucky has rebounded to record the targeted 5% increase in the community employment of SCL participants from the post-recession low (2013/14 data).

Since Medicaid is the funder of last resort, 95% of the waiver participants newly entering the workforce will receive employment services through the Office of Vocational Rehabilitation for at least six months up to about 24 months before their first waiver prior authorization for employment is requested. This means that only a handful of waiver participants who decided to seek community employment upon entering SCL2 are actually being funded through the waiver. We have attempted to obtain an estimate of the number of "new" VR clients who receive waiver services but that number is not tracked.

While we recognized that our previous process for delivering employment services to waiver participants was flawed, we had no idea exactly how flawed it was until we visited supported employment providers and conducted utilization reviews to determine the efficacy of the supports being provided as supported employment. The result of the utilization review was the recognition that a large percentage of persons receiving supported employment services had actually completely mastered their jobs and were receiving supports 100% of the time due to guardian's requests, an incorrect assessment of the crisis needs of the individual, and a lack of understanding of the requirements of supported employment. Recognition of these facts resulted in the conversion of a large number of supported employment prior authorizations to adult day training or personal assistance.

If there is a change in the person's disability or the emergence of a secondary disability that significantly impacts a person's ability to work, the person is entitled to receive a second set of services through vocational rehabilitation.

Prior to the implementation of SCL2, this reality was not addressed. When we initiated this process with SCL2, the percentage of requests receiving a second segment of service through OVR went from negligible to around 40%. It has since settled in between 30-35% on average.

When comparing the supported employment rate and the day training rate, even with the increase in the supported employment rate for SCL and the reduction of the adult day training rate, the provider income generated per staff member for adult day training still exceeds the income generated for supported employment.

Supported employment is delivered on a one to one basis and generates $41 per hour of service per staff member.

Even the most conservative estimates place the average staff to participant ratio for adult day treatment at one staff member to five participants. With that ratio adult day training generates $48.40 per hour of service per staff member.

(a) Comment: Shannon McCracken, Interim Executive Director, Kentucky Association of Private Providers; Brittany Knoth, Executive Director Path Forward of KY;
Robert J. Illback, PsyD, ABPP, President and Chief Executive Officer of REACH of

Louisville; Stephen S. Zaricki, MSW, Executive Director Community Living, Inc.; David Coons Family Home Provider; Meghen Wilson Growing Minds Learning Center; Jenifer C. Frommeyer, Executive Director Dreams With Wings; Leah F. Campbell, JD, Chief Operating Officer Apple Patch Community; Tomika H. Cosby, Executive Director Kentucky Case Management; Steve Frommeyer, Parent of a recipient of waiver services; Leigh Denniston of Almcare; Diane Quarles-Hartman, BS/MHA, Executive Director, Evergreen Life Services; Pamela J. Millay, R.N., J.D, Clinical Director/CPO Redwood; Myra Gribbins, Owner/Executive Director Reach for the stars Case Management; and Brad Schneider Vice President, Developmental Services Division LifeSkills, Inc. stated the following:

"The minor changes in the qualifications for Community Access Specialist in no way justify a decrease in the Community Access rate, especially when the changes do not "broaden the qualifications" as promised in the summary page. The under utilization of the service over year 2014 and 2015 to date, has been due to the barriers placed upon the Specialist qualifications, the lack of knowledge and support of QA's to providers, and the limitations upon it as an "impact service."

(b) Response: There has not been a decrease in the rate for community access.

(a) Comment: Maria Alagia Cull, ResCare made the following comment:

Community Access services were introduced in 2014 as an alternative to Day Training activities to promote increased integration in the individual's community hoping, that by developing new relationships, the need for paid supports would decrease. This time-limited program was introduced at the expense of the Day Training program. The Day Training program supports the development of new skills to support greater independence as well as employment.

The individuals served by ResCare, and by the majority of providers of services to individuals with intellectual disabilities, receive Day Training services rather than Community Access services. While the reimbursement rate for Day Training service was reduced in 2014 to accommodate a new service, Community Access, few individuals are taking advantage of this new, untested and potentially dangerous service. Community Access services apply the principles of Supported Employment delivered in a controlled setting to a community situation where risk factors cannot be fully mitigated.

Community Access should be removed from the general services provisions of the regulation and tested as a pilot program in an appropriate area of the state. Day Training services have been proven to provide safe opportunities for personal development. The reduction in funding for Day Training services to fund Community Access services has negatively impacted some providers' ability to implement increased offsite activities due to the subsequent rise in transportation cost. The rising cost and decrease in revenue results in an unsustainable situation that adversely impacts the individuals receiving services. The Day Training services program must be amended to

comply with the new CMS Home and Community Based Waiver rules that promote increased integration within community settings. The Community Access services, however, are not the best approach. In the current design, Community Access services do not appeal' to assist individuals to meet the desired outcome of integration to the point where paid supports are reduced.

Recently, one of ResCare's participants who has some significant behavioral issues, was assessed and the case manager and the Department agreed that the participant should stop attending ResCare's program and access the community from his home. This participant has a one-on-one staff person who assists him to do the things he likes to do which include, among other things, going to the mall and one of the local animal shelters. The state agreed that this was a good alternative but that ResCare could not bill for this service because there is no payment for day program access from a residential site. The activities involving going to the animal shelter are related to the outcomes delineated in his person-centered plan. This example proves that a day program without walls to focus on personal outcomes would be an appropriate means of achieving this participant's personal goal.

ResCare suggests that the Cabinet establish a workgroup to establish a meaningful Community Access program with appropriate supports and appropriate reimbursement to ensure compliance with federal guidelines and the guiding principles of the Olmstead decision. ResCare would like to participate in the workgroup.

(b) Response: Thank you for your comments and offer to participate in future efforts to improve waiver services.

(5) Subject: Non-PDS Provider Participation Requirements

(a) Comment: Johnny Callebs, Regional/Executive Director Independent Opportunities-Richmond, made the following comment:

“Quality Improvement Plan: (v) Improve the participant’s competence is vague.

Availability of Records: Why should the Department of Aging and Independent Living have access to a person’s SCL record if PDS or state guardianship is not involved? Please remove this requirement.”

(b) Response: Regarding the quality improvement plan, DMS will file an “amended after comments” regulation in which it will delete the following statement from the regulation:

“(v) Improve the participant’s competence.”

DAIL would only seek access to a record regarding individuals with which DAIL is involved.

(a) Comment: Shannon McCracken, Interim Executive Director, Kentucky Association of Private Providers; Brittany Knoth, Executive Director Path Forward of KY;

Robert J. Illback, PsyD, ABPP, President and Chief Executive Officer of REACH of Louisville; Stephen S. Zaricki, MSW, Executive Director Community Living, Inc.; David Coons Family Home Provider; Meghen Wilson Growing Minds Learning Center; Jenifer C. Frommeyer, Executive Director Dreams With Wings; Leah F. Campbell, JD, Chief Operating Officer Apple Patch Community; Tomika H. Cosby, Executive Director Kentucky Case Management; Steve Frommeyer, Parent of a recipient of waiver services; Leigh Denniston of Almcare; Diane Quarles-Hartman, BS/MHA, Executive Director, Evergreen Life Services; Pamela J. Millay, R.N., J.D, Clinical Director/CPO Redwood; Myra Gribbins, Owner/Executive Director Reach for the stars Case Management; and Brad Schneider Vice President, Developmental Services Division LifeSkills, Inc. stated the following:

"Annual Check of Caregiver Misconduct Registry – please change to 25% sample rather than all employees.

Johnny Callebs, Regional/Executive Director Independent Opportunities-Richmond, made the following comment:

Annual Check of Caregiver Misconduct Registry: Please change to 25% sample rather than all employees."

(b) Response: DMS will file an "amended after comments" regulation to change the requirement to a twenty-five percent sample as it has historically done with related background checks. The revisions are as displayed below:

(y) Shall on an annual basis:
1. Randomly select and perform criminal history background checks, nurse aide abuse registry checks, **[~~and~~]** central registry checks**, and caregiver misconduct registry checks** of at least twenty-five (25) percent of employees; [~~and~~]."

(a) Comment: Shannon McCracken, Interim Executive Director, Kentucky Association of Private Providers; Brittany Knoth, Executive Director Path Forward of KY;
Robert J. Illback, PsyD, ABPP, President and Chief Executive Officer of REACH of Louisville; Stephen S. Zaricki, MSW, Executive Director Community Living, Inc.; David Coons Family Home Provider; Meghen Wilson Growing Minds Learning Center; Jenifer C. Frommeyer, Executive Director Dreams With Wings; Leah F. Campbell, JD, Chief Operating Officer Apple Patch Community; Tomika H. Cosby, Executive Director Kentucky Case Management; Steve Frommeyer, Parent of a recipient of waiver services; Leigh Denniston of Almcare; Diane Quarles-Hartman, BS/MHA, Executive Director, Evergreen Life Services; Pamela J. Millay, R.N., J.D, Clinical Director/CPO Redwood; Myra Gribbins, Owner/Executive Director Reach for the stars Case Management; and Brad Schneider Vice President, Developmental Services Division LifeSkills, Inc. stated the following:

"Please remove this requirement for the DBHDID Crisis Prevention and Intervention Training and allow providers to use other crisis prevention systems they have already

invested in and have proven to be effective."

Johnny Callebs, Regional/Executive Director Independent Opportunities-Richmond, made the following comment:

"DBHDID Crisis Prevention and Intervention Training: Please remove this requirement and allow providers to use other crisis prevention systems they have already invested in and have proven to be effective."

(b) Response: The required crisis training is important to promote restraint-free supports. The DBHDID crisis prevention and intervention training does not prevent providers from providing additional training of their choosing.

(6) Subject: Residential Supports

(a) Comment: Johnny Callebs, Regional/Executive Director Independent Opportunities-Richmond, made the following comment:

"Residential Supports Level 1: a participant may spend no more than five unsupervised hours per day. Why only five hours? This seems like an arbitrary number. If a person can safely spend an increasing number of hours unsupervised, he/she should be encouraged to do so in moving toward greater independence. Please remove this restriction."

(b) Response: If the participant is able to increase the number of unsupervised hours then the team may want to consider residential level II supports as well as supporting the person to live independently with in-home supports.

(a) Comment: Shannon McCracken, Interim Executive Director, Kentucky Association of Private Providers; Brittany Knoth, Executive Director Path Forward of KY; Robert J. Illback, PsyD, ABPP, President and Chief Executive Officer of REACH of Louisville; Stephen S. Zaricki, MSW, Executive Director Community Living, Inc.; David Coons Family Home Provider; Meghen Wilson Growing Minds Learning Center; Jenifer C. Frommeyer, Executive Director Dreams With Wings; Leah F. Campbell, JD, Chief Operating Officer Apple Patch Community; Tomika H. Cosby, Executive Director Kentucky Case Management; Steve Frommeyer, Parent of a recipient of waiver services; Leigh Denniston of Almcare; Diane Quarles-Hartman, BS/MHA, Executive Director, Evergreen Life Services; Pamela J. Millay, R.N., J.D, Clinical Director/CPO Redwood; Myra Gribbins, Owner/Executive Director Reach for the stars Case Management; and Brad Schneider Vice President, Developmental Services Division LifeSkills, Inc. stated the following:

"The Person Centered Team should determine the amount of unsupervised time for a participant in a Level I Residential support. Five hours seems like an arbitrary number. If a person can safely spend an increasing number of hours unsupervised, he or she should be encouraged to do so in moving forward toward greater independence.

Please remove this restriction”

(b) Response: If the participant is able to increase the number of unsupervised hours, then Residential Level II supports may be considered as well as supporting the person to live independently with in-home supports.

(a) Comment: Therapeutic Intervention Services, PLLC, made the following comment:

“Section 4.16.3 Its should be left: up to the Person Centered Team to determine the amount of unsupervised time for a participant in a Level I residential support.”

(b) Response: If the participant is able to increase the number of unsupervised hours then the team may want to consider residential level II supports as well as supporting the person to live independently with in-home supports.

(a) Comment: Shannon McCracken, Interim Executive Director, Kentucky Association of Private Providers; Brittany Knoth, Executive Director Path Forward of KY; Robert J. Illback, PsyD, ABPP, President and Chief Executive Officer of REACH of Louisville; Stephen S. Zaricki, MSW, Executive Director Community Living, Inc.; David Coons Family Home Provider; Meghen Wilson Growing Minds Learning Center; Jenifer C. Frommeyer, Executive Director Dreams With Wings; Leah F. Campbell, JD, Chief Operating Officer Apple Patch Community; Tomika H. Cosby, Executive Director Kentucky Case Management; Steve Frommeyer, Parent of a recipient of waiver services; Leigh Denniston of Almcare; Diane Quarles-Hartman, BS/MHA, Executive Director, Evergreen Life Services; Pamela J. Millay, R.N., J.D, Clinical Director/CPO Redwood; Myra Gribbins, Owner/Executive Director Reach for the stars Case Management; and Brad Schneider Vice President, Developmental Services Division LifeSkills, Inc. stated the following

“In 2013 KAPP was supportive of “the addition of progressive residential options in the waiver, such as Technology Assisted and Shared Living. KAPP understands the rate adjustments in the more traditional models, Family Home Providers and staffed residences. The concern is that these modest increases will be quickly absorbed and counteracted by the increase in administrative burdens and costs, associated with additional waiver requirements and unfunded mandates.

“Also notable, providers report that the Technology and Shared Living service models are virtually unutilized.”

(b) Response: Thank you for your comments. No rate changes are being considered for the regulation at this time.

(a) Comment: Shannon McCracken, Interim Executive Director, Kentucky Association of Private Providers; Brittany Knoth, Executive Director Path Forward of KY; Robert J. Illback, PsyD, ABPP, President and Chief Executive Officer of REACH of Louisville; Stephen S. Zaricki, MSW, Executive Director Community Living, Inc.;

David Coons Family Home Provider; Meghen Wilson Growing Minds Learning Center; Jenifer C. Frommeyer, Executive Director Dreams With Wings; Leah F. Campbell, JD, Chief Operating Officer Apple Patch Community; Tomika H. Cosby, Executive Director Kentucky Case Management; Steve Frommeyer, Parent of a recipient of waiver services; Leigh Denniston of Almcare; Diane Quarles-Hartman, BS/MHA, Executive Director, Evergreen Life Services; Pamela J. Millay, R.N., J.D, Clinical Director/CPO Redwood; Myra Gribbins, Owner/Executive Director Reach for the stars Case Management; and Brad Schneider Vice President, Developmental Services Division LifeSkills, Inc. stated the following:

“Technology Assisted Services: Regulation requires --- Be furnished in a provider---owned or leased residence: does provider own all homes? Are individuals not allowed to rent their own homes? Should this be changed to: “Be furnished in the participants home”.”

(b) Response: The regulation language does allow for this service in the person’s home as displayed in the following excerpt:

“Technology assisted residential services shall:
1. Be furnished in a participant’s residence.”

(a) Comment: Shannon McCracken, Interim Executive Director, Kentucky Association of Private Providers; Brittany Knoth, Executive Director Path Forward of KY;
Robert J. Illback, PsyD, ABPP, President and Chief Executive Officer of REACH of Louisville; Stephen S. Zaricki, MSW, Executive Director Community Living, Inc.;
David Coons Family Home Provider; Meghen Wilson Growing Minds Learning Center; Jenifer C. Frommeyer, Executive Director Dreams With Wings; Leah F. Campbell, JD, Chief Operating Officer Apple Patch Community; Tomika H. Cosby, Executive Director Kentucky Case Management; Steve Frommeyer, Parent of a recipient of waiver services; Leigh Denniston of Almcare; Diane Quarles-Hartman, BS/MHA, Executive Director, Evergreen Life Services; Pamela J. Millay, R.N., J.D, Clinical Director/CPO Redwood; Myra Gribbins, Owner/Executive Director Reach for the stars Case Management; and Brad Schneider Vice President, Developmental Services Division LifeSkills, Inc. stated the following:

“Technology Assisted Services: Regulation requires -- three (3) or fewer participants who previously resided in the residence with twenty-four (24) hour staff support; Does everyone in KY have 24/7 supports? So, if someone doesn’t have 24/7 supports currently they can’t use remote monitoring? This needs to be changed to: ‘To three (3) or fewer participants who through the use of technology assisted residential services reduce the amount of in home staff support’.”

(b) Response: DMS will file an “amended after comments” regulation with the Legislative Research Commission to adopt the recommendation. The revised language will read as follows:

“b. To three (3) or fewer participants who “through the use of technology assisted residential services reduce the amount of in-home staff support [~~reside in the residence with twenty-four (24) hour staff support~~].”

(a) Comment: Shannon McCracken, Interim Executive Director, Kentucky Association of Private Providers; Brittany Knoth, Executive Director Path Forward of KY; Robert J. Illback, PsyD, ABPP, President and Chief Executive Officer of REACH of Louisville; Stephen S. Zaricki, MSW, Executive Director Community Living, Inc.; David Coons Family Home Provider; Meghen Wilson Growing Minds Learning Center; Jenifer C. Frommeyer, Executive Director Dreams With Wings; Leah F. Campbell, JD, Chief Operating Officer Apple Patch Community; Tomika H. Cosby, Executive Director Kentucky Case Management; Steve Frommeyer, Parent of a recipient of waiver services; Leigh Denniston of Almcare; Diane Quarles-Hartman, BS/MHA, Executive Director, Evergreen Life Services; Pamela J. Millay, R.N., J.D, Clinical Director/CPO Redwood; Myra Gribbins, Owner/Executive Director Reach for the stars Case Management; and Brad Schneider Vice President, Developmental Services Division LifeSkills, Inc. stated the following:

“Technology Assisted Services: Regulation requires --- A video camera, which shall not be located in a bedroom or a bathroom; what if cameras are needed in these areas for health/safety needs and the individual consents and/or wants them there. I don’t think there is a need to define the system configuration other than a statement indicating that the team must approve the system configuration in the home. Something like: “The participant and the support team shall determine and approve the configuration of the remote monitoring system components”.”

(b) Response: The department is concerned that such surveillance may violate privacy laws and is not comfortable removing the prohibition as this time but will further research the issue.

(a) Comment: Shannon McCracken, Interim Executive Director, Kentucky Association of Private Providers; Brittany Knoth, Executive Director Path Forward of KY; Robert J. Illback, PsyD, ABPP, President and Chief Executive Officer of REACH of Louisville; Stephen S. Zaricki, MSW, Executive Director Community Living, Inc.; David Coons Family Home Provider; Meghen Wilson Growing Minds Learning Center; Jenifer C. Frommeyer, Executive Director Dreams With Wings; Leah F. Campbell, JD, Chief Operating Officer Apple Patch Community; Tomika H. Cosby, Executive Director Kentucky Case Management; Steve Frommeyer, Parent of a recipient of waiver services; Leigh Denniston of Almcare; Diane Quarles-Hartman, BS/MHA, Executive Director, Evergreen Life Services; Pamela J. Millay, R.N., J.D, Clinical Director/CPO Redwood; Myra Gribbins, Owner/Executive Director Reach for the stars Case Management; and Brad Schneider Vice President, Developmental Services Division LifeSkills, Inc. stated the following:

“Technology Assisted Services: Regulation requires --- A technology assisted residential service provider shall have a plan established to ensure that staff is available

twenty---four (24) hours a day, seven (7) days a week for a participant or participants receiving services from the provider. What staff must be available? The remote monitoring staff or residential staff? I'm guessing this is their statement that back---up or on--- call staff must be available and ready to respond to the home when the remote monitoring company dispatches them."

(b) Response: The person centered team would identify appropriate staffing for twenty-four hour availability.

(a) Comment: Shannon McCracken, Interim Executive Director, Kentucky Association of Private Providers; Brittany Knoth, Executive Director Path Forward of KY; Robert J. Illback, PsyD, ABPP, President and Chief Executive Officer of REACH of Louisville; Stephen S. Zaricki, MSW, Executive Director Community Living, Inc.; David Coons Family Home Provider; Meghen Wilson Growing Minds Learning Center; Jenifer C. Frommeyer, Executive Director Dreams With Wings; Leah F. Campbell, JD, Chief Operating Officer Apple Patch Community; Tomika H. Cosby, Executive Director Kentucky Case Management; Steve Frommeyer, Parent of a recipient of waiver services; Leigh Denniston of Almcare; Diane Quarles-Hartman, BS/MHA, Executive Director, Evergreen Life Services; Pamela J. Millay, R.N., J.D, Clinical Director/CPO Redwood; Myra Gribbins, Owner/Executive Director Reach for the stars Case Management; and Brad Schneider Vice President, Developmental Services Division LifeSkills, Inc. stated the following:

"We also commented in 2013 on the Room and Board formula as it had never been included in the regulation before: Within the SCL Waiver amendment there was a significant clause defining what providers could charge recipients for room and board costs; which is defined as lease payments on the home, groceries, utilities and other cost of living expenses. Room and Board fees are neither directly reimbursed through the waiver nor are they a Medicaid support. Similar waivers in neighboring states and throughout do not typically define the amount a provider can charge for room and board so we request the Cabinet re---evaluate defining these costs within the waiver. Currently, the case more so than not is that provider agencies subsidize a significant portion of living expenses for those they support in residential settings, this acts as a further encumbrance for providers. KAPP's formal position paper on this matter was submitted to Medicaid Commissioner Kissner. The Commissioner did meet with us on the subject, but declined to remove the Room and Board formula.

KAPP's request for the past 2 years has been to remove the room and board formula from the regulation. This is not a reimbursable service and should not be defined in regulation. The person centered team and conflict---free case manager should monitor this responsibly."

(b) Response: Thank you for your comment. This requirement standardizes maximum costs and protects the individual.

(a) Comment: Shannon McCracken, Interim Executive Director, Kentucky Association of

Private Providers; Brittany Knoth, Executive Director Path Forward of KY; Robert J. Illback, PsyD, ABPP, President and Chief Executive Officer of REACH of Louisville; Stephen S. Zaricki, MSW, Executive Director Community Living, Inc.; David Coons Family Home Provider; Meghen Wilson Growing Minds Learning Center; Jenifer C. Frommeyer, Executive Director Dreams With Wings; Leah F. Campbell, JD, Chief Operating Officer Apple Patch Community; Tomika H. Cosby, Executive Director Kentucky Case Management; Steve Frommeyer, Parent of a recipient of waiver services; Leigh Denniston of Almcare; Diane Quarles-Hartman, BS/MHA, Executive Director, Evergreen Life Services; Pamela J. Millay, R.N., J.D, Clinical Director/CPO Redwood; Myra Gribbins, Owner/Executive Director Reach for the stars Case Management; and Brad Schneider Vice President, Developmental Services Division LifeSkills, Inc. stated the following:

"Please remove requirements for room and board charges. Should not be in Medicaid waiver. It is not a reimbursable service and should not be defined in regulation. Allow providers to establish individually."

Johnny Callebs, Regional/Executive Director Independent Opportunities-Richmond, made the following comment:

"Room and Board: Please remove requirements for room and board charges and allow providers to establish the charges."

(b) Response: Thank you for your comment. This requirement standardizes maximum costs and protects the individual.

(a) Comment: Shannon McCracken, Interim Executive Director, Kentucky Association of Private Providers; Brittany Knoth, Executive Director Path Forward of KY; Robert J. Illback, PsyD, ABPP, President and Chief Executive Officer of REACH of Louisville; Stephen S. Zaricki, MSW, Executive Director Community Living, Inc.; David Coons Family Home Provider; Meghen Wilson Growing Minds Learning Center; Jenifer C. Frommeyer, Executive Director Dreams With Wings; Leah F. Campbell, JD, Chief Operating Officer Apple Patch Community; Tomika H. Cosby, Executive Director Kentucky Case Management; Steve Frommeyer, Parent of a recipient of waiver services; Leigh Denniston of Almcare; Diane Quarles-Hartman, BS/MHA, Executive Director, Evergreen Life Services; Pamela J. Millay, R.N., J.D, Clinical Director/CPO Redwood; Myra Gribbins, Owner/Executive Director Reach for the stars Case Management; and Brad Schneider Vice President, Developmental Services Division LifeSkills, Inc. stated the following:

"The expectations for Staffed Residence include: no more than three participants, ensuring the participant has privacy in the sleeping or living unit in the residential setting, an option for a private unit in a residential setting, a unit with lockable entrance doors and with only the individual and appropriate staff having keys to those doors, a choice of roommates or housemates, the freedom to furnish or decorate the participant's sleeping or living units, visitors of the participant's choosing at any time and

access to a private area for visitors, be considered physically accessible that is easy to approach, enter, operate or participate in a safe manner and with a dignity by a person with or without a disability and that meets the American Disability Act, being for a participant who requires a 24 hour a day, intense level of support with no more than 5 unsupervised hours per day per participant, to promote independence and based on the needs of the participant as determined by the participant's person centered team. The current expectations of DDID and many case managers are that each individual be served independently regardless of the other individuals living in the home or their wishes. This is not the expectation in a family home provider setting or in any home for that matter. If an individual and/or their guardian chooses this option of a staffed residence which the state supports in the waiver, the specific wants and needs of an individual cannot be met concurrently at the residential rate, which funds 1 staff per 3 people. It is concerning that the assumption is the only person of importance is the individual without any concern to the others living in the home. We should be advocating for each individual to get what he or she need with respect to the environment in which they have chosen to live and for the people they live with.

(b) Response: Each waiver recipient who is prior authorized to receive a residential service is entitled to receive the support defined by the regulation. This level of support does not in any way preclude the possibility of supporting each person living in the home to exercise choice and does not dictate staffing ratios. Staffing should be based on the support needs of each person receiving services which is informed by the person centered process. Providers receive reimbursement for each person supported.

(a) Comment: Lisa A. (Chaplin) Wise, BS Special Edu, Assistant Director Communicare made the following comment:

"Section 4: Covered Services Residential Support Services; Participants are provided with opportunity to have visitors of their choosing but having a visitor at any time of the day could cause safety and privacy issues for other participants in the home. For instance, one female participant contacts a male via Craiglist and invites this male visitor to her home (bedroom) at 2am."

(b) Response: The CMS final rule requires that waiver participants be provided with the opportunity to have visitors of their choosing at any time. Discussions regarding safe and healthy lifestyle choices made by the participants shall be supported by the person centered team.

(a) Comment: Maria Alagia Cull, ResCare made the following comment:

"Several clarifications are necessary for Section 4(17) of the regulation which addresses Technological Assisted Residential Services. The regulation prohibits a video camera from being located in a bedroom or a bathroom. The Cabinet should consider changing the language to accommodate all situations such as "the participant and the support team shall determine and approve the configuration of the remote monitoring system components." In addition, the regulation should specify which staff person/people are

required to be available on a 24/7 basis as required in Section 17(2).

Based on its experience in other states, ResCare suggests that Kentucky look at programs in Ohio as an example of a state with mature waiver programs that have evolved to address person-centered care through both policy and payment."

(b) Response: The department is concerned that such surveillance may violate privacy laws and is not comfortable removing the prohibition as this time but will further research the issue.

The person centered team would identify appropriate staffing for twenty-four hour availability.

Thank you for your suggestion.

(7) Subject: Human Rights Committee Quorum

(a) Comment: Johnny Callebs, Regional/Executive Director Independent Opportunities-Richmond, made the following comment:

"The required ten person membership of the committee is too difficult to maintain and should be reduced by at least half. The requirement for a quorum of eight members is unrealistic. I'm not aware of any functioning committee where 80% of members must attend to constitute a quorum."

Shannon McCracken, Interim Executive Director, Kentucky Association of Private Providers; Brittany Knoth, Executive Director Path Forward of KY;
Robert J. Illback, PsyD, ABPP, President and Chief Executive Officer of REACH of Louisville; Stephen S. Zaricki, MSW, Executive Director Community Living, Inc.;
David Coons Family Home Provider; Meghen Wilson Growing Minds Learning Center;
Jenifer C. Frommeyer, Executive Director Dreams With Wings; Leah F. Campbell, JD, Chief Operating Officer Apple Patch Community; Tomika H. Cosby, Executive Director Kentucky Case Management; Steve Frommeyer, Parent of a recipient of waiver services; Leigh Denniston of Almcare; Diane Quarles-Hartman, BS/MHA, Executive Director, Evergreen Life Services; Pamela J. Millay, R.N., J.D, Clinical Director/CPO Redwood; Myra Gribbins, Owner/Executive Director Reach for the stars Case Management; and Brad Schneider Vice President, Developmental Services Division LifeSkills, Inc. stated the following:

"The required ten---person membership of the Human Rights committee is too difficult to maintain and should be reduced by at least half. The requirement for a quorum of eight members is unrealistic. We aren't aware of any functioning committee where 80% of members must attend to constitute a quorum. It is a facility model that is difficult and unnecessary to implement in the community setting."

(b) Response: DMS is filing an "amended after comments" regulation with the

Legislative Research Commission to reduce the quorum requirement from eight (8) to six (6) individuals with at least one (1) self-advocate and one (1) community at-large member having to be present.

(8) Subject: Behavior Intervention Committee

(a) Comment: Johnny Callebs, Regional/Executive Director Independent Opportunities-Richmond, made the following comment:

“The required seven person membership of the committee is too difficult to maintain and should be reduced to three or four.”

Shannon McCracken, Interim Executive Director, Kentucky Association of Private Providers; Brittany Knoth, Executive Director Path Forward of KY;
Robert J. Illback, PsyD, ABPP, President and Chief Executive Officer of REACH of Louisville; Stephen S. Zaricki, MSW, Executive Director Community Living, Inc.;
David Coons Family Home Provider; Meghen Wilson Growing Minds Learning Center;
Jenifer C. Frommeyer, Executive Director Dreams With Wings; Leah F. Campbell, JD, Chief Operating Officer Apple Patch Community; Tomika H. Cosby, Executive Director Kentucky Case Management; Steve Frommeyer, Parent of a recipient of waiver services; Leigh Denniston of Almcare; Diane Quarles-Hartman, BS/MHA, Executive Director, Evergreen Life Services; Pamela J. Millay, R.N., J.D, Clinical Director/CPO Redwood; Myra Gribbins, Owner/Executive Director Reach for the stars Case Management; and Brad Schneider Vice President, Developmental Services Division LifeSkills, Inc. stated the following:

“The required seven---person membership of the Behavior Intervention committee is too difficult to maintain and should be reduced to three or four.”

(b) Response: The makeup of the Behavior Intervention Committee was developed in collaboration with SCL positive behavior support specialists using their expertise to inform the decision. The required number of Behavior Intervention Committee members was reduced from ten to seven after input from multiple area Committees. Reducing it further would not allow for sufficient community membership for appropriate consideration of alternative often common-sense interventions and review of the plans to reduce or rescind the rights restriction.

(a) Comment: Therapeutic Intervention Services, PLLC, made the following comment:

“Section 8 (a) In Section 7,Human Rights Committee, the regulations establishes a quorum but it fails to do so for Behavior Intervention Committee. Is there a 1 reason whv this left out of the regulation?”

Melissa Renn Brown, Executive Director/Program Director, SCL and MPW Waiver Services, Down Syndrome of Louisville, Inc. stated the following:

“Section 8 Pages 134 The definition of a quorum for BIC meetings is not defined as it is for HRC meetings.”

(b) Response: The makeup of the Behavior Intervention Committee was developed in collaboration with SCL positive behavior support specialists using their expertise to inform the decision. The required number of Behavior Intervention Committee members was reduced from ten to seven after input from multiple area committees.

DMS is filing an “amended after comments” regulation with the Legislative Research Commission which will establish the following quorum requirements for BIC meetings:

“(b) A Behavior Intervention Committee meeting shall have a quorum of at least five (5) members including at least one (1):
1. Self-advocate, representative, or family member;
2. Member from the community at large with experience in:
a. Human rights issues; or
b. The field of intellectual or developmental disabilities;
3. Professional in the medical field;
4. Positive behavior support specialist; and
5. Professional comprised of any combination of a:
a. Positive behavior support specialist;
b. Licensed psychologist;
c. Certified psychologist; or
d. Licensed clinical social worker.”

(a) Comment: Jodi Wilson, Regional Director of ResCare, made the following comment:

“The requirements for regional HRC and BIC are unmanageable and very hard to achieve in some of the more spread out locations/regions. Further, the reviews often appear to be rubber-stamped and lack the in depth personal review to ensure individual rights are truly protected.”

Maria Alagia Cull, ResCare made the following comment:

“These Committees do not meet the needs of the people they seek to serve nor do they comply with the nationally accepted standards of practice for these Committees. ResCare has internal Committees that duplicate these entities. These Committees have become rubber stamps.”

(b) Response: Case managers are required to present sufficient information for a thorough and considered review of rights issues including environmental and best practice considerations. The work of the committees is left to the professional expertise of the members and should not be a rubber stamp. If there are specific issues or concerns with a committee, the department is happy to provide technical assistance.

(a) Comment: Shannon McCracken, Interim Executive Director, Kentucky Association of

Private Providers; Brittany Knoth, Executive Director Path Forward of KY; Robert J. Illback, PsyD, ABPP, President and Chief Executive Officer of REACH of Louisville; Stephen S. Zaricki, MSW, Executive Director Community Living, Inc.; David Coons Family Home Provider; Meghen Wilson Growing Minds Learning Center; Jenifer C. Frommeyer, Executive Director Dreams With Wings; Leah F. Campbell, JD, Chief Operating Officer Apple Patch Community; Tomika H. Cosby, Executive Director Kentucky Case Management; Steve Frommeyer, Parent of a recipient of waiver services; Leigh Denniston of Almcare; Diane Quarles-Hartman, BS/MHA, Executive Director, Evergreen Life Services; Pamela J. Millay, R.N., J.D, Clinical Director/CPO Redwood; Myra Gribbins, Owner/Executive Director Reach for the stars Case Management; and Brad Schneider Vice President, Developmental Services Division LifeSkills, Inc. stated the following:

"In 2013, KAPP commented: This structure is clearly based upon facility models, where doctors, nurses, psychiatrists, dieticians and therapists are on staff and on site. In the community, the challenge to find volunteer professionals who will commit full days to these committees is a daunting task.

Today we find: The mandated concept of regional HRC/BIC committees is limited in scope (e.g. does not review medications, policy, or have proactive functions and restricts availability to provider teams), in function, and often does not meet the needs of the agencies.

KAPP's recommendation for the past 2 years has been to revise the stringent requirements in the SCL Policy Manual referencing Area HRC and Area BIC, especially regarding membership. It is a facility model that is difficult to implement in the community setting."

(b) Response: DMS is filing an "amended after comments" regulation with the Legislative Research Commission which will reduce the quorum requirement for the Human Rights Committee from eight to six members as follows:

"(4) A Human Rights Committee meeting shall have a quorum of at least six (6) [~~eight (8)~~] members at least one (1) of which shall be a self-advocate and one (1) of which shall be a community at large member."

The Behavior Intervention Committee was developed in collaboration with SCL positive behavior support specialists using their expertise to inform the decision. The required number of Behavior Intervention Committee members was reduced from ten to seven after input from multiple area committees.

(a) Comment: Christopher D. George, M.Ed., BCBA, LBA owner and Executive Director of Applied Behavioral Advancements made the following comment:

"I do want to thank the Cabinet for a couple of things. The wording changes for the Behavior Intervention Committee to only require new or revised plans to go through

them is a great efficiency and time savings for those of us who run the BICs. I thank you for that. I was also very pleased with all of the good behavior analytic language that has been incorporated in under CCT and some other areas as well. So, thank you for that as well."

(b) Response: Thank you for your comments.

(9) Subject: Incident Reporting

(a) Comment: Johnny Callebs, Regional/Executive Director Independent Opportunities-Richmond, made the following comment:

"Requiring incidents to be entered into the MWMA portal by the person who discovered or witnessed the incident is too burdensome. The person will have to come to an office location to access the portal. It would be better if the person completes an incident report form and is permitted to turn it in for entry by designated agency staff. Requiring critical incidents involving abuse, neglect and exploitation to be entered immediately into the portal is not feasible as staffed residences and group homes are not equipped with company computers for portal access. This would also be a problem for most family home providers and adult foster care providers. If an incident occurs after hours or on weekends or holidays, staff cannot access the portal to meet the requirement. The same situation applies to the requirement that critical incidents not involving abuse, neglect, and exploitation be reported within eight hours. The regulation does not contain provisions for reporting on the next business day or an alternative to entering the incident immediately into the MWMA portal."

Shannon McCracken, Interim Executive Director, Kentucky Association of Private Providers; Brittany Knoth, Executive Director Path Forward of KY;
Robert J. Illback, PsyD, ABPP, President and Chief Executive Officer of REACH of Louisville; Stephen S. Zaricki, MSW, Executive Director Community Living, Inc.;
David Coons Family Home Provider; Meghen Wilson Growing Minds Learning Center; Jenifer C. Frommeyer, Executive Director Dreams With Wings; Leah F. Campbell, JD, Chief Operating Officer Apple Patch Community; Tomika H. Cosby, Executive Director Kentucky Case Management; Steve Frommeyer, Parent of a recipient of waiver services; Leigh Denniston of Almcare; Diane Quarles-Hartman, BS/MHA, Executive Director, Evergreen Life Services; Pamela J. Millay, R.N., J.D, Clinical Director/CPO Redwood; Myra Gribbins, Owner/Executive Director Reach for the stars Case Management; and Brad Schneider Vice President, Developmental Services Division LifeSkills, Inc. stated the following:

"Requiring incidents to be entered into the MWMA portal by the person who discovered or witnessed the incident is too burdensome. The person will have to come to an office location to access the portal. It would be better if the person completes an incident report form and is permitted to turn it in for the entry by designated agency staff. Requiring critical incidents involving abuse, neglect and exploitation to be entered immediately into the MWMA portal is not feasible as staffed residences and group

homes are not equipped with company computers for portal access. This would also be a problem for most family home providers and adult foster care providers. If an incident occurs after hours or on weekends or holidays, staff cannot access the portal to meet the requirement. The same situation applies to the requirement that critical incidents not involving abuse, neglect and exploitation be reported within eight hours. The regulation does not contain provisions for reporting on the next business day or an alternative to entering the incident immediately into the MWMA portal."

Therapeutic Intervention Services, PLLC, made the following comment:

"For Critical Incident Reports, language requiring the writer of the Incident ' Report to notify the Case Manager and Guardian has been removed from the regulation. It seems that one of the most important notification when reporting the suspicion of abuse, neglect, and exploitation is APS/CPS and then the guardian.

Additionally in situations of the suspicion of abuse, neglect, and exploitation, the regulation states that staff are to make an immediate report to the MWMA system. This is difficult for any staff who are at the time providing any community-based services and may not have access to a computer and internet at the time of a critical incident It seems extremely unrealistic to hold a staff accountable of making this report in the system. There should be a system for staff to make the notifications immediately when they do not have access to the system.

Melissa Renn Brown, Executive Director/Program Director, SCL and MPW Waiver Services, Down Syndrome of Louisville, Inc. stated the following:

"Section 11 (4) (a) 1 lf the "individual that discovered or witnessed" the incident is required to make the entry into MWMA Will every DSP be required to have an account through MWMA in order to complete an incident report or may the agency representative with MWMA complete the report."

Lisa A. (Chaplin) Wise, BS Special Edu, Assistant Director Communicare made the following comment:

Section 11 Incident Reporting Process "Will this be for all direct care (over 70 employees), residential (over 200 employees) PDS Employees (over 1500), day training (over 100 employees), etc and if this is a requirement via MWMA would will be providing internet access to all people who may witness an incident? How can an incident be immediately reported if the witness and the participant are in the community when the incident occurs? Who will be responsible for managing all employee log in information into MWMA? How much access will be given to the employees to view/change/access/ those incident reports; especially in relation to PDS Employees who are not employed by the agency but rather by the participant? Also consider that the Case management agency will be different than the provider agency due to conflict-free case management. Will all providers be given MWMA access to all participants they serve? How will this be managed and implemented while continuing to protect participant's privacy right? Who

will be responsible for providing the MWMA portal trainings to each and every person/employee who may need to report and incident in the portal?"

(b) Response: Thank you for your comments. DMS will file an "amended after comment" administrative regulation with the Legislative Research Commission to revise subsections (4) and (5) as follows:

"(4)(a) If an incident occurs, the individual who discovered or witnessed the incident shall:
1. Document the details of the incident and report it to agency staff for [~~Report the incident by making an~~] entry into the MWMA portal [~~that includes details regarding the incident [Be documented on an Incident Report form~~]; and
2. Be immediately assessed for potential abuse, neglect, or exploitation."

"(5)(a) . . .
(b) If the critical incident:
2. Does not require reporting of abuse, neglect, or exploitation, the critical incident shall be reported via the MWMA portal by a designated agency staff person [~~the individual who witnessed or discovered the critical incident~~] within eight (8) hours of discovery.

Since the reports are made directly into the portal in real time there is no need for the next business day requirement.

(a) Comment: Jodi Wilson, Regional Director of ResCare, made the following comment:

"Also, while I am on my soap box, I have great issue with the ambiguity of the regulation in many places, most especially with regards to incident management. It leaves too much open for interpretation. If they want us to play by the rules give us solid rules that we all can follow without having to ask so many questions or waiting to see which way the wind is blowing."

(b) Response: Thank you for your comment.

(a) Comment: Melissa Renn Brown, Executive Director/Program Director, SCL and MPW Waiver Services, Down Syndrome of Louisville, Inc. stated the following:

"Section 11 (4) (b) 5-7 Page 145 Since these lines have been removed from the regulations, the SCL provider is no longer required to maintain copies of the incident reports?"

(b) Response: The incident report information will be maintained in MWMA as long as an SCL provider is actively supporting an SCL participant and has access to all records required for that participant. Paper copies are not required; however, providers are required to maintain records for six years. Therefore the agency will need to develop a mechanism for maintaining access to a participant's records for that timeframe even though the records may not be accessible through MWMA if the participant is no longer

supported by that provider at any point in time. The key is to be able to generate a copy of the record.

(a) Comment: Melissa Renn Brown, Executive Director/Program Director, SCL and MPW Waiver Services, Down Syndrome of Louisville, Inc. stated the following:

“Section 11 (5) (b) 1-2 Page 145 If DCBS is no longer required to be notified of an incident involving Abuse Neglect or Exploitation, how will the APS/CPS report/investigation be generated?

(b) Response: Notification to DCBS is generated by the MWMA.

(10) Subject: Medicaid Waiver Management Application (MWMA)

(a) Comment: Johnny Callebs, Regional/Executive Director Independent Opportunities-Richmond, made the following comment:

“Using MWMA for SCL records should be voluntary, not mandatory. So far there have been two massive data breaches, so HIPAA requirements are certainly a concern. Also, it will be nearly impossible to have portal access at all service locations.

Shannon McCracken, Interim Executive Director, Kentucky Association of Private Providers; Brittany Knoth, Executive Director Path Forward of KY;
Robert J. Illback, PsyD, ABPP, President and Chief Executive Officer of REACH of Louisville; Stephen S. Zaricki, MSW, Executive Director Community Living, Inc.;
David Coons Family Home Provider; Meghen Wilson Growing Minds Learning Center;
Jenifer C. Frommeyer, Executive Director Dreams With Wings; Leah F. Campbell, JD, Chief Operating Officer Apple Patch Community; Tomika H. Cosby, Executive Director Kentucky Case Management; Steve Frommeyer, Parent of a recipient of waiver services; Leigh Denniston of Almcare; Diane Quarles-Hartman, BS/MHA, Executive Director, Evergreen Life Services; Pamela J. Millay, R.N., J.D, Clinical Director/CPO Redwood; Myra Gribbins, Owner/Executive Director Reach for the stars Case Management; and Brad Schneider Vice President, Developmental Services Division LifeSkills, Inc. stated the following:

“Using MWMA for SCL records should be voluntary, not mandatory. Also, it will be nearly impossible to have portal access at all service locations. The Cabinet needs to reevaluate the project including its security. Providers should not be held to a higher standard of HIPAA compliance than the Cabinet.

In the transition process, there have been 2 major HIPAA breaches, which allowed all case managers in the state to view the Private Health Information of every participant in the system, across the state. The first was on April 24th, and the second on September 14th. Both were reported to the Cabinet as well as Deloitte. Both times, only Deloitte responded with a patch to fix the problem, but we received no answer from the Cabinet on how to address the HIPAA Breach.”

(b) Response: The Cabinet for Health and Family Services HIPAA Privacy Officer conducted an investigation of two suspected breaches and determined that NO breach occurred.

(a) Comment: Shannon McCracken, Interim Executive Director, Kentucky Association of Private Providers; Brittany Knoth, Executive Director Path Forward of KY; Robert J. Illback, PsyD, ABPP, President and Chief Executive Officer of REACH of Louisville; Stephen S. Zaricki, MSW, Executive Director Community Living, Inc.; David Coons Family Home Provider; Meghen Wilson Growing Minds Learning Center; Jenifer C. Frommeyer, Executive Director Dreams With Wings; Leah F. Campbell, JD, Chief Operating Officer Apple Patch Community; Tomika H. Cosby, Executive Director Kentucky Case Management; Steve Frommeyer, Parent of a recipient of waiver services; Leigh Denniston of Almcare; Diane Quarles-Hartman, BS/MHA, Executive Director, Evergreen Life Services; Pamela J. Millay, R.N., J.D, Clinical Director/CPO Redwood; Myra Gribbins, Owner/Executive Director Reach for the stars Case Management; and Brad Schneider Vice President, Developmental Services Division LifeSkills, Inc. stated the following:

“The Medicaid Waiver Management Application, a project being developed and implemented by Deloitte, is referenced in nearly every service section of the proposed regulation.

The rollout for MWMA for Case Managers has been unsuccessful and chaotic. Providers cannot seek advice from their Quality Administrators, as they aren’t familiar with the system. Case Managers were trained directly by Deloitte and their project manager and help desk assistants are our only resource for answers and help. They do not understand the differences in each waiver, leaving case managers frustrated and without answers. The deadlines for implementation have been delayed repeatedly, including the last one targeted for September 1st because the system is not ready, problems are unresolved and many participants cannot be transitioned for various reasons. One example is that some participants have wrong addresses, which have to be changed through KAMES, which they have to work with DCBS to resolve. This can take hours and multiple phone calls to get one person’s address changed. KAPP has attempted to work with DCBS for answers. The resolution of the problem will not happen overnight. KAPP requests that DCBS designate personnel specifically to assist in this process.”

“Since the Deloitte timeline for MWMA has not been successful (and still is not ready) for Case Management, it seems impossible that the next phase will be ready by December for other service providers to use. The inclusion of entry into MWMA all throughout the regulation seems very premature and unlikely to comply with.”

(b) Response: Deadlines for case managers to transition waiver participant information into MWMA have been extended because not all case managers completed the transition within the initial deadlines. The wrong addresses are not caused by MWMA.

The addresses are what are currently stored in the Kentucky Automated Management Eligibility System (KAMES) which is why they have to be resolved through the KAMES.

The MAP-22 is to be used for address changes. As of October 2, 2015, there were more than 20,000 members uploaded into MWMA.

(a) Comment: Melissa Renn Brown, Executive Director/Program Director, SCL and MPW Waiver Services, Down Syndrome of Louisville, Inc. stated the following:

"Section 3 (3) (o) page 40 Since a Participant record will be maintained on MWMA, provider agencies should not have to duplicate those records since providers should have access in December."

(b) Response: As long as an SCL provider is actively supporting an SCL participant and has access to all records required for that participant, paper copies are not required. However, providers are required to maintain records for six years; therefore, the agency will need to develop a mechanism for maintaining access to a participant's records for that timeframe even though the records may not be accessible through MWMA if the participant is no longer supported by that provider at any point in time. The key is to be able to generate a copy of the record.

(a) Comment: Jean M Russell, Vice President, Developmental Services, Seven Counties Services, stated the following:

"Page 20 Section 3 Initially, this system was to be a mechanism for individuals to enroll in a waiver program. Currently, the state continues to expand the requirements of what must be included in this system resulting in much duplication of effort and documentation for each provider. We request that this system only be used as an enrollment portal and not duplicate requirements of clinical documentation."

(b) Response: MWMA is a mechanism for individuals to enroll in a waiver program. The next release includes the ability to record service notes for every service within MWMA. Currently, providers must provide the notes to case managers. When providers enter the notes directly into MWMA they will no longer separately have to send them to case managers.

(a) Comment: Jean M Russell, Vice President, Developmental Services, Seven Counties Services, stated the following:

"Page 31,34,38,40,52 Section 4,The regulation now includes the requirement of the Case Manager to upload documentation related to the services: Community Access, Community Transition Services, Environmental Accessibility Adaptation Service, Goods and Services, Shared Living, Speech Language Pathology, and Supported Employment. These documents do not have an impact on application and essentially duplicate a clinical record. We are asking the state to remove this requirement and refrain from adding any additional service documentation to be included in the MWMA

system as well as in the clinical record to prevent this duplication of effort."

(b) Response: The next release includes the ability to record service notes for every service within MWMA. Currently, providers must provide the notes to case managers. When providers enter the notes directly into MWMA they will no longer separately have to send them to case managers.

(a) Comment: Therapeutic Intervention Services, PLLC, made the following comment:

"Who is primarily responsible for the setting up and maintenance or the records required in the MWMA system, case management agencies or service providers? If it is expected that records are to be kept in the MWMA system, then it providers should not have to maintain a duplicate record keeping system. It is redundant and costly. Is there any ability for the MWMA to interface with a providers Electronic Medical Record? There is no clear language in the regulation for Providers maintaining their own records.

(b) Response: The provider agency will be responsible for ensuring access to all records required for reviews. With the next release each provider will be able to enter their agency documentation in MWMA. Currently, providers must provide the notes to case managers. When providers enter the notes directly into MWMA they will no longer separately have to send them to case managers.

MWMA contains an electronic record that is available to the provider while they are providing a service to the individual. The electronic record will not be available to the provider when they do not provide a service. Due to record retention requirements providers will need to have a process for maintaining a record when no longer providing the service. At this time MWMA does not interface with individual provider electronic medical records (EMR) systems.

While there is the ability to enter some health information in the accompanying data and documents section of MWMA, MWMA is a waiver long term services and supports system application and does not meet the criteria for Certification Commission for Healthcare Information Technology (CCHIT) or Office of the National Coordinator for Health IT - Authorized Testing and Certification Body (ONC-ATCB) certification of a Long Term and Post-Acute Care(LTPAC) Electronic Health Record.

Although not ready for the scheduled December 2015 release the vision is for MWMA to follow interoperability standards to exchange information via the Kentucky Health Information Exchange (KHIE). Onboarding to KHIE will give a provider the ability to exchange electronic health information between entities that are also part of the information exchange, unlike the limited functionality of an interface, exchanging information through KHIE provides access to acute care facilities, behavioral health, medical providers, or any other provider/agency connected to the exchange.

In the future KHIE will connect to the national exchange allowing exchange of information nationally. Although LTPAC electronic health record (EHR) interoperability

is in the beginning stages, the Office of the National Coordinator for Health Information Technology is starting to develop a set of standards for LTPAC, specifically an LTSS information exchange (eLTSS) standard, of which Kentucky is a participating pilot state.

All initiatives are in piloting phases but the LTSS community is certainly a large part of the Health Information Technology (HIT) interoperability roadmap.

(a) Comment: Steven Shannon, Executive Director, Kentucky Association of Regional Programs, Inc. made the following comment:

“Section 3 delineates the provider requirements for not PDS services. Section 3. (3) (o) indicates a provider “Shall maintain a record in the MWMA portal for each participant served.” Will the record in the Medicaid Waiver Management Application be the official record for the participant? If not, will the MWMA record interface with providers’ electronic health record? We realize these questions have been asked repeatedly but there are still concerns the MWMA will result in unnecessary record duplication and will not interface with electronic billing systems maintained by providers. Also, how will credentialing organizations such as the Joint Commission (formerly JCAHO) and CARF review MWMA records during an accreditation review?”

(b) Response: The provider agency will be responsible for ensuring access to all records required for reviews.

(a) Comment: Lili S. Lutgens, JD, LCSW Therapeutic Intervention Services, PLLC, made the following comment:

“Proposed regulation 907 KAR 12:010 requires all service providers to "maintain a record in the MWMA portal for each participant served" (pg. 40 line 5) including documentation of each contact. Further,CA services and notes are to be included in the MWMA system. pg.62 line 7. At the same time, 907 KAR
12:010 continues to require SCL providers to maintain a participant's file for six years from either the last date on which a service was provided or,for individuals under the age of 21 at the time of service, 6 years after the person turns 21years of age. pg.39 lines 7 -11.

It appears then that the Cabinet is requiring SCL providers to maintain two sets of records,one electronic record in the MWMA system and their own record (whether paper or electronic) in their office.

We are in the process of investing thousands of dollars in an electronic medical records system designed to help us to be more efficient but this efficiency is lost if we have to maintain client records
in a second electronic database,the MWMA, and especially if we are required to upload notes.

We certainly understand why the Cabinet for Health and Family Services would want to

create a centralized database for Waiver services and why they would want those documents central to Case Management duties to be uploaded into the system. Among the benefits of a centralized, complete database including contact dates and service notes is the ability of staff in Frankfort to conduct audits from Frankfort. What we do not understand, however, is the benefit to requiring all SCL providers to maintain a second system of records that mirrors what is kept in the MWMA system.

We have absorbed significant cuts in the amount of money we receive for providing our services. At the same time, additional administrative requirements make our services more expensive to provide. We respectfully request that the Cabinet recognize this reduction in funding and determine if the MWMA is to be a centralized database into which all SCL providers upload all documentation, which database the Cabinet maintains and out of which they fulfill record requests, or if the SCL providers are to maintain separate records without the requirement that all documents especially contact dates and notes be uploaded into the state MWMA."

(b) Response: There is no plan for credentialing organizations to have log-in credentials for MWMA. With the next release each provider will be able to enter their agency documentation into MWMA.

Currently, providers must provide the notes to case managers. When providers enter the notes directly into MWMA they will no longer separately have to send them to case managers.

MWMA contains an electronic record that is available to the provider while they are providing a service to the individual. The electronic record will not be available to the provider when they do not provide a service. Due to record retention requirements providers will need to have a process for maintaining a record when no longer providing the service. The Medicaid program is subject to audit by various parties including the Centers for Medicare and Medicaid Services (CMS) – who provide federal funding for the program and who can recoup payments due to a lack of documentation of services – as well as the Kentucky Office of the Auditor of Public Accounts.

(a) Comment: Shannon McCracken, Interim Executive Director, Kentucky Association of Private Providers; Brittany Knoth, Executive Director Path Forward of KY; Robert J. Illback, PsyD, ABPP, President and Chief Executive Officer of REACH of Louisville; Stephen S. Zaricki, MSW, Executive Director Community Living, Inc.; David Coons Family Home Provider; Meghen Wilson Growing Minds Learning Center; Jenifer C. Frommeyer, Executive Director Dreams With Wings; Leah F. Campbell, JD, Chief Operating Officer Apple Patch Community; Tomika H. Cosby, Executive Director Kentucky Case Management; Steve Frommeyer, Parent of a recipient of waiver services; Leigh Denniston of Almcare; Diane Quarles-Hartman, BS/MHA, Executive Director, Evergreen Life Services; Pamela J. Millay, R.N., J.D, Clinical Director/CPO Redwood; Myra Gribbins, Owner/Executive Director Reach for the stars Case Management; and Brad Schneider Vice President, Developmental Services Division LifeSkills, Inc. stated the following:

“Supported Employment shall be documented in MWMA, the new Medicaid Waiver Management Application. KAPP is concerned that MWMA is not ready for implementation based upon the issues within the case management rollout. The lack of program readiness in addition to the lack of provider training and support by DBHDID staff, add to that concern.”

Shannon McCracken, Interim Executive Director, Kentucky Association of Private Providers; Brittany Knoth, Executive Director Path Forward of KY;
Robert J. Illback, PsyD, ABPP, President and Chief Executive Officer of REACH of Louisville; Stephen S. Zaricki, MSW, Executive Director Community Living, Inc.;
David Coons Family Home Provider; Meghen Wilson Growing Minds Learning Center; Jenifer C. Frommeyer, Executive Director Dreams With Wings; Leah F. Campbell, JD, Chief Operating Officer Apple Patch Community; Tomika H. Cosby, Executive Director Kentucky Case Management; Steve Frommeyer, Parent of a recipient of waiver services; Leigh Denniston of Almcare; Diane Quarles-Hartman, BS/MHA, Executive Director, Evergreen Life Services; Pamela J. Millay, R.N., J.D, Clinical Director/CPO Redwood; Myra Gribbins, Owner/Executive Director Reach for the stars Case Management; and Brad Schneider Vice President, Developmental Services Division LifeSkills, Inc. stated the following:

“Community Access shall be documented in MWMA. KAPP is concerned that MWMA is not ready for implementation based upon the issues within the case management rollout. The lack of program readiness in addition to the lack of provider training and support by DBHDID staff, add to that concern.”

(b) Response: MWMA has been implemented. The next release includes the ability to record service notes for every service within MWMA.

Currently, providers must provide the notes to case managers. When providers enter the notes directly into MWMA they will no longer separately have to send them to case managers.

Training materials are being developed to include waiver specific instruction. As providers and DBHDID staff use MWMA all will become more knowledgeable about it. It is necessary for both providers and DBHDID to designate staff to train new staff in the use of MWMA.

(a) Comment: Melissa Renn Brown, Executive Director/Program Director, SCL and MPW Waiver Services, Down Syndrome of Louisville, Inc. stated the following:

“Section 4 (22) (f) 2 If no other services are entered into MWMA it is not necessary for the PCEP to be entered. Additionally this is a process that typically occurs through OVR.”

Melissa Renn Brown, Executive Director/Program Director, SCL and MPW Waiver

Services, Down Syndrome of Louisville, Inc. also stated the following:

“Section 4 (22) (f) 10 Page 114 If no other service is required to submit notes to MWMA it should not be a requirement for Supported employment services.”

(b) Response: The next release includes the ability to record service notes for every service within MWMA. DMS is filing an “amended after comments” regulation adds the MWMA requirement to other services.

(a) Comment: Steven Shannon, Executive Director, Kentucky Association of Regional Programs, Inc. made the following comment:

“Section 2 (1) (f) indicates that an individual’s representative may upload information to the MWMA portal. Please clarify what mechanisms will be established to ensure individuals have access to technology to allow them to upload documents and information in the MWMA portal. While the regulation indicates there are alternatives to the individual’s representative uploading information, will some individuals lack of access to technology pose a barrier to SCL participation.”

Lisa A. (Chaplin) Wise, BS Special Edu, Assistant Director Communicare made the following comment:

Section 5 Person Centered Service Plan Requirements “Will each participant and/or participant’s representative be provided MWMA user logins to submit/upload their Map 116 into the portal? If so, who will be responsible for managing all of these logins for participant’s and their representatives?

(b) Response: All citizens of Kentucky can create an account in the Kentucky Online Gateway (Kynect). Currently, through Kynect individuals can seek insurance plans. With the next release of MWMA citizens will use their Kynect login to access MWMA. Paper application and supporting documentation will still be accepted.

(11) Subject: Citation Typo

(a) Comment: Melissa Renn Brown, Executive Director/Program Director, SCL and MPW Waiver Services, Down Syndrome of Louisville, Inc. stated the following:

“Section 1 (95) Definitions – pg 26 The Citation should read “42 CFR 400.203.”

(b) Response: Thank you. The Legislative Research Commission corrected the typo via a “technical amendment” subsequent to DMS’s filing of the regulation.

(12) Subject: Tuberculosis Testing

(a) Comment: Comment: Melissa Renn Brown, Executive Director/Program Director, SCL and MPW Waiver Services, Down Syndrome of Louisville, Inc. stated the following:

“Section 3 (3) (q) 1-2 Page 43 Negative TB test results typically do not expire for two years based on medical practice. In this case for negative results TB test should only have to be done every other year unless the results are positive for TB.”

(b) Response: The Cabinet for Health and Family Services, Department for Public Health has filed a new administrative regulation regarding TB testing/assessment requirements - 902 KAR 20:205 – and it requires that TB risk assessments be performed annually for health care workers. This is consistent with SCL regulatory requirements.

(13) Subject: National Background Check

(a) Comment: Melissa Renn Brown, Executive Director/Program Director, SCL and MPW Waiver Services, Down Syndrome of Louisville, Inc. stated the following:

“Section 3 (3) (y) Page 45 If an agency uses the Kentucky National Background Check based on 906 KAR 1:190, There are no accommodations for this as it applies to annual background checks.”

(b) Response: The Kentucky National Background Check program requirements pursuant to 906 KAR 1:190 – which is addressed in paragraph (w)2 - would apply for the pre-employment check requirements, but could not be used to satisfy the additional annual background checks [twenty-five (25) percent sample] addressed in paragraph (y). The annual sample is an additional requirement.

(14) Subject: Restriction of an Impact Service

(a) Comment: Melissa Renn Brown, Executive Director/Program Director, SCL and MPW Waiver Services, Down Syndrome of Louisville, Inc. stated the following:

“Section 4 (4) (m) Page 62 Remove the restriction of an impact service. In practice this clause has created delays and loss of necessary supports because the terms of approvals are too short to develop the necessary natural supports to remove paid supports.”

(b) Response: Community access will remain an impact service. It is designed as a bridge to connect and empower a participant to develop networks of natural support and become less reliant on formal supports. Impact services are not intended as restricted services.

Services such as community access are expected to have a significant effect on a person’s ability to engage with other people in the local community. Prior authorizations for this service are limited to up to six months per request; however, should the person require ongoing community access service beyond a six month prior authorization, the person centered team may request ongoing services based on the person’s ongoing

need for assistance to connect with community members. The service provision should decrease as the person develops the skills needed to maintain the connection within the community. Other SCL services such as day training and residential services should be utilized if needed when community access services are withdrawn to assist the person with any additional needs such as personal care, financial management, or transportation.

(15) Subject: Therapies

(a) Comment: Jean M Russell, Vice President, Developmental Services, Seven Counties Services, stated the following:

"Page 40, 43 Section 4, Though the CMS directive is clear in the necessity of this action, mechanisms put in place in Kentucky for the providers of these services to individuals with an Intellectual and/or Developmental Disability have created several unintended barriers which are likely to result in a decrease in access for these consumers. These barriers include:
A. The requirement of providers to obtain a CON for becoming an Outpatient Rehab Agency if the entity provides more than one service. The regulations of an ORA add additional cost to the providers and will be a deterrent particularly with the reduced rate of reimbursement.
B. Current providers are working to obtain their Medicaid number, yet this process has been arduous and it has been reported that many providers have worked for over 12 months and still do not have their Medicaid number.
C. The lower reimbursement rates for these services will have a significant impact on providers willing to serve this population.
We request the state consider exempting therapy providers from the CON requirement for Medicaid covered services. Additionally, we request the state increase the reimbursement for these services to the prior waiver rates."

(b) Response: Thank you for your comment. At this time, there is no change to the certificate of need (CON) process. For the most recently completed state fiscal year (which ended June 30, 2015) the average length of time to process and complete a provider's enrollment in the Medicaid Program was 56 days. Applications that contained errors or were incomplete take longer; thus, DMS encourages applicants to make sure that they complete the application in entirety and provide the required documentation.

The cabinet is actively working on a therapy transition plan with the Centers for Medicare and Medicaid Services (CMS) to assure that waiver participants will not lose their services and to attempt to close the gap in the payment rates between the state plan and the waiver.

(a) Comment: William S. Dolan, Staff Attorney Supervisor, Protection and Advocacy, made the following comment:

"The changes to Section 4 delete occupational, physical, and speech therapy, OT, VT,

ST) as SCL services. These services will now be delivered under the State Plan. We are concerned that this amendment will result in SCL recipients being denied OT, PT, and ST as State Plan reimbursement rates are dramatically less and, by definition, State Plan services are not community-based like waiver services. Also, will these State Plan therapies continue to be approved as habilitation or will they now be limited to rehabilitation only? Some SCL recipients need therapies to learn rather than regain a skill. We recommend keeping OT, PT, and ST as SCL services."

(b) Response: Thank you for your comment. The cabinet is actively working on a therapy transition plan with CMS to assure that waiver participants will not lose their services and to attempt to close the gap in the payment rates between the state plan and the waiver. Any physical therapy, occupational therapy, or speech-language pathology services' needs that a waiver participant has will be met through the state plan. Removing these services from the SCL waiver has been unequivocally mandated by CMS upon the cabinet and is not optional.

(a) Comment: Christopher D. George, M.Ed., BCBA, LBA owner and Executive Director of Applied Behavioral Advancements stated the following:
"I'd like to reiterate that I am in much agreement with many of the comments that have been made previously, especially those about the removal of OT, PT and speech. As a provider of those services, and I guess this is more commentary seeing as how we have been instructed in the House Bill 144 commission that this is a rule from the Federal CMS as far as being the removal of those services. However, that removes a key component to a person-centered team plan. Certainly, as we look at the training requirements that are required to serve this population, as well as participation in the person-centered team to provide a multi-disciplinary approach to service delivery. The removal of those services, then, sends that out to anyone on the street who may do that. They may not have experience with the individuals that we serve. They may not have experience and are not regulatorily required to participate in that person-centered team plan. So, although I do realize that the Cabinet's hands are somewhat tied, I am saddened by that decision."

(b) Response: Thank you for your input. As noted, DMS has no choice as this is a federal mandate.

(a) Comment: Jodi Wilson, Regional Director of ResCare, made the following comment:

"I have GREAT concern regarding the elimination of key therapies. Although I understand what a waiver really is, I cannot help but feel that shortly we will discover that the people we care deeply about will not get key services they need because of access and availability of community providers. These supports are so very important and can often be life-changing for some people and to just lose them with no clear cut means to secure them in a system so very challenged disturbs me and scares me. It would be great to transition the current waiver through a series of steps the end goal being people receiving therapies in the community as others do. At least, make the

ability for therapist to get medicaid provider numbers more easily.

(b) Response: Thank you for your comment. The cabinet is actively working on a therapy transition plan with CMS to assure that waiver participants will not lose their services. For the most recently completed state fiscal year (which ended June 30, 2015) the average length of time to process and complete a provider's enrollment in the Medicaid Program was 56 days. DMS is very willing to expedite enrollment of these providers.

(a) Comment: Christopher D. George, M.Ed., BCBA, LBA owner and Executive Director of Applied Behavioral Advancements stated the following:

"At the very end where we talk about specialized medical equipment and supplies -- and this is more of like a technical side -- underneath it, it says that the -- that recommended in order to do specialized medical equipment and so forth, recommended by a person whose signature -- who meets the specialized equipment, blah, blah, blah, blah. It meets the personnel training requirements established at Section 3 of this Administrative Regulation and is an occupational therapist, physical therapist or speech language pathologist. Seeing as how they were no longer included in this regulation and no longer under #3, I would recommend that that language be removed, especially the reference to the training requirements."

(b) Response: Specialized medical equipment and supplies are still a covered benefit under this waiver program and must be recommended by a physical therapist, occupational therapist, or speech-language pathologist.

(16) Subject: Waiver Application and Participants' Work Choices

(a) Comment: Jean M Russell, Vice President, Developmental Services, Seven Counties Services; Shannon McCracken, Interim Executive Director, Kentucky Association of Private Providers; Brittany Knoth, Executive Director Path Forward of KY; Robert J. Illback, PsyD, ABPP, President and Chief Executive Officer of REACH of Louisville; Stephen S. Zaricki, MSW, Executive Director Community Living, Inc.; David Coons Family Home Provider; Meghen Wilson Growing Minds Learning Center; Jenifer C. Frommeyer, Executive Director Dreams With Wings; Leah F. Campbell, JD, Chief Operating Officer Apple Patch Community; Tomika H. Cosby, Executive Director Kentucky Case Management; Steve Frommeyer, Parent of a recipient of waiver services; Leigh Denniston of Almcare; Diane Quarles-Hartman, BS/MHA, Executive Director, Evergreen Life Services; Pamela J. Millay, R.N., J.D, Clinical Director/CPO Redwood; Myra Gribbins, Owner/Executive Director Reach for the stars Case Management; and Brad Schneider Vice President, Developmental Services Division LifeSkills, Inc. stated the following:

"The waiver application should consider and be sensitive to the participants who may want to work, but due to intensive medical, behavioral or even legal issues may always require support staff. The answer is not for DT staff to provide that support at the

current Day Training rate. In a 1:1 scenario like that, the staff person would likely be making a wage not equal to the participant they are supporting. Furthermore, if the participant has such “long-term” support needs which are not uncommon in a “long-term” support waiver, the process should not be so difficult and burdensome for the case manager, the SE provider and for the participant to obtain Prior Authorization for services. The conflict-free case management component should be the trusted entity to work with the team and ensure the person is not receiving more supports than they need or require. The Long Term Support Plan definition needs another component for on-going support in these situations, not just monitoring 6 hours or less per month. Specific examples may be provided upon request.

(b) Response: The protocol for supported employment is as follows:

Participants receive the amount of support that they need to maintain their employment; but nothing beyond what is needed. The needed support may be comprised of a number of SCL services.

People needing assistance completing the specific tasks that they have been hired to complete should receive supported employment services as defined in their Long-Term Employment Support Plan (LTESP). There should be a fading plan included in the LTESP to assist the consumer to work toward independence.

People needing direct assistance due to personal care, behavioral, or medical needs including transportation (that cannot be provided using other Medicaid funded means) that are documented by the support team as being an ongoing current need of the consumer should receive personal Assistance if they live in their own residence or with their own family (not a family home provider).

If they receive residential services, personal assistance is the responsibility of the residential provider.

People needing assistance because “something might happen”, at the request of the consumer’s family or guardian, or at the request of the employer should receive day training services. Typically the provision of services in this situation indicates a poor job match and if the consumer wishes should be replaced with a better matched job. The delivery of services under these circumstances are also contrary to the goals of the program, which are to help people live their lives as part of the community.

All people receiving waiver services in the community should receive at least six hours of supported employment in order to maintain their employment.

(a) Comment: Shannon McCracken, Interim Executive Director, Kentucky Association of Private Providers; Brittany Knoth, Executive Director Path Forward of KY;
Robert J. Illback, PsyD, ABPP, President and Chief Executive Officer of REACH of Louisville; Stephen S. Zaricki, MSW, Executive Director Community Living, Inc.;
David Coons Family Home Provider; Meghen Wilson Growing Minds Learning Center;

Jenifer C. Frommeyer, Executive Director Dreams With Wings; Leah F. Campbell, JD, Chief Operating Officer Apple Patch Community; Tomika H. Cosby, Executive Director Kentucky Case Management; Steve Frommeyer, Parent of a recipient of waiver services; Leigh Denniston of Almcare; Diane Quarles-Hartman, BS/MHA, Executive Director, Evergreen Life Services; Pamela J. Millay, R.N., J.D, Clinical Director/CPO Redwood; Myra Gribbins, Owner/Executive Director Reach for the stars Case Management; and Brad Schneider Vice President, Developmental Services Division LifeSkills, Inc. stated the following:

"We request an allowance and realistic understanding for participants who may choose not to work. Not every person in the SCL waiver can or desires to, leaving their ONLY options for a "meaningful day"…an underfunded, overcrowded, understaffed Day Training model OR worse, sitting at home. For Kentucky to sincerely comply with the CMS Rule in the next 4 years, the barriers to true Supported Employment for everyone must be removed."

(b) Response: The protocol for supported employment is as follows:

Participants receive the amount of support that they need to maintain their employment; but nothing beyond what is needed. The needed support may be comprised of a number of SCL services.

People needing assistance completing the specific tasks that they have been hired to complete should receive supported employment services as defined in their Long-Term Employment Support Plan (LTESP). There should be a fading plan included in the LTESP to assist the consumer to work toward independence.

People needing direct assistance due to personal care, behavioral, or medical needs including transportation (that cannot be provided using other Medicaid funded means) that are documented by the support team as being an ongoing current need of the consumer should receive personal Assistance if they live in their own residence or with their own family (not a family home provider).

If they receive residential services, personal assistance is the responsibility of the residential provider.

People needing assistance because "something might happen" at the request of the consumer's family or guardian or at the request of the employer should receive day training services. Typically the provision of services in this situation indicates a poor job match and, if the consumer wishes, should be replaced with a better-matched job. The delivery of services under these circumstances is also contrary to the goals of the program, which are to help people live their lives as part of the community.

All people receiving waiver services in the community should receive at least six hours of supported employment in order to maintain their employment.

(17) Subject: Day Training

(a) Comment: Jean M Russell, Vice President, Developmental Services, Seven Counties Services, stated the following:

"Page 48 Section C1/C3, The expectations for Day Training include: supporting the participation in daily, meaningful, routines of the community which for adults may include work-like settings that do not meet the definition of SE. DT services stress training in the activities of daily living, self-advocacy, adaptive and social skills and are age and culturally appropriate. The training, activities and routines established shall not be diversional in nature but rather, shall be meaningful to the person, shall provide an appropriate level of variation and interest, and shall assist the person to achieve personally chosen outcomes which are documented in the POC. These services can be provided at a fixed location or in community settings. The hours must be spent in training and program activities and must be based on each individual's Plan of Care. In addition, Day Training may include involvement in community based activities that assist the person in increasing his/her ability to access community resources and being involved with other members of the general population. How can a provider effectively serve a person, meeting the important requirements above, at a rate of $9.16 per hour? The costs of running a quality day training center, if that was the only service you chose to provide could only be covered at about a 10:1 ratio, at best. In order to meet the expectation for this service, the rates must reflect the ability to provide 1:1 or 1:2 service to participants."

(b) Response: The hourly rate for day training is a per person rate. Day training is not a one-on-one service. An agency may support any number of participants in a day setting. If as you state a 10:1 ratio is used, using the current day training rate of $2.20 per 15 minute unit, the amount billed per hour would be $88.00.

Community access is available to all waiver participants. It is not necessarily expected that a participant would achieve total independence within a natural setting within six months. However, within the six-month prior authorized period, concrete objectives specified in the plan should have been accomplished. If additional supports are needed to advance the person's ultimate outcome, they may be requested through a plan modification.

The expectation is that careful and deliberate person centered planning will result in customized supports tailored to the specific needs and desires of the person involved. This will vary immensely from person to person and may include paid or unpaid supports.

Community access services are designed to enable people to have increased access to community resources and offer opportunities for people to develop personal social networks by building friendships and making connections with other people in their local communities. Impact services, such as community access, are expected to have a significant effect on a person's ability to engage with other people in the local

community. Prior authorizations for this service are limited to up to six months per request; however, should the person require ongoing community access service beyond a six month prior authorization, the person centered team may request ongoing services based on the person's ongoing need for assistance to connect with community members. The service provision should decrease as the person develops the skills needed to maintain the connection within the community. Other SCL services such as day training and residential services should be utilized, if needed, when community access services are withdrawn, to assist the person with any additional needs, such as personal care, financial management or transportation.

(a) Comment: Shannon McCracken, Interim Executive Director, Kentucky Association of Private Providers; Brittany Knoth, Executive Director Path Forward of KY; Robert J. Illback, PsyD, ABPP, President and Chief Executive Officer of REACH of Louisville; Stephen S. Zaricki, MSW, Executive Director Community Living, Inc.; David Coons Family Home Provider; Meghen Wilson Growing Minds Learning Center; Jenifer C. Frommeyer, Executive Director Dreams With Wings; Leah F. Campbell, JD, Chief Operating Officer Apple Patch Community; Tomika H. Cosby, Executive Director Kentucky Case Management; Steve Frommeyer, Parent of a recipient of waiver services; Leigh Denniston of Almcare; Diane Quarles-Hartman, BS/MHA, Executive Director, Evergreen Life Services; Pamela J. Millay, R.N., J.D, Clinical Director/CPO Redwood; Myra Gribbins, Owner/Executive Director Reach for the stars Case Management; and Brad Schneider Vice President, Developmental Services Division LifeSkills, Inc. stated the following:

"The expectations for Day Training include: supporting the participant in daily, meaningful, routines of the community, which for adults may include work---like settings that do not meet the definition of SE. DT services stress training in the activities of daily living, self---advocacy, adaptive and social skills and are age and culturally appropriate. The training, activities and routines established shall not be diversional in nature but rather, shall be meaningful to the person, shall provide an appropriate level of variation and interest, and shall assist the person to achieve personally chosen outcomes which are documented in the POC. These services can be provided at a fixed location or in community settings. The hours must be spent in training and program activities and must be based on each individual's Plan of Care. In addition, Day Training may include involvement in community---based activities that assist the person in increasing his/her ability to access community resources and being involved with other members of the general population.

The costs of running a quality day training center, if that was the only service you chose to provide could only be covered at about a 10:1 ratio, at best. In order to meet the expectation for this service, the rates must either reflect the ability to provide 1:1 or 1:2 service to participants who ALL deserve it or remove the barriers to Community Access which have been identified and make it a service everyone can provide and receive.

There are over 4,000 waiver recipients still utilizing the Day Training Service. It is a wanted and needed service, but one that could be much higher quality and more

community based with the appropriate funding. The waiver application, based upon trend, predicts there will still be over 4,000 people in Day Training centers 5 years from now.

For Kentucky to sincerely comply AND succeed with the CMS Rule in the next 4 years, the barriers to true Community Access and quality Day Training centers, for everyone must be removed."

(b) Response: The commenter referenced the career development track of adult day training and represents that to provide activities related to career development would require a 1:1 or 1:2 staff ratio. Examples of career development activities are as follows:

 Being Punctual - Time Concepts and the understanding of being on time and ready for a work period. Mastery of scheduling can be a significant part of any pre-vocational program.

 Developing a consistent attendance record – understanding that if one is going to work they must make a commitment to do his or her job on both good days and bad.

 Dressing appropriately – we often take this element for granted or depend upon residential staff to provide assistance. In reality, it is not enough for the person to know what is appropriate to be worn. They should also receive assistance to understand why it is appropriate.

 Preparation for a work period - going to a designated "work" place, (even a table designated for work-oriented tasks), and getting out and later putting away necessary materials should be reinforced.

 Following directions - This may include pictorial guides. This element would focus on the understanding of sequential events. What happens first, next, and last. It also includes language (or communications) development in general. Responding to one-step directions, then two-steps, three steps and so on. It may also include taking notes or being able to relate information previously given. Memory games and songs are a good way to build these skills.

 Discrimination of objects - by color, shape, and size. Sorting between two different elements, then three, then four...

 Understanding work concepts and employer expectations - Learning about increasing productivity - placing materials in sequence to be assembled, timed tasks, improvement of on-task behaviors, etc.

 Completing tasks – developing the capacity to work through the entire task, from beginning to end.

 Problem solving - learning what to do when things don't quite go the way you expected.
 Achieving quality standards –

 Adopting workplace safety habits –

 Vocational awareness - learning about different types of occupations and the skills basic to those jobs. Visiting work settings and role-playing are great exercises in this area.

 None of these tasks require a 1:1 or 1:2 staff to participant ratio. Likewise, the other suggested day training tracks: health and wellness, community integration, and support retirement do not require such individualized attention.

(a) Comment: Jan Eblen, President, Kentucky Association for Community Employment Services made the following comment:

"As part of the 2012 implementation of the new Supports for Community Living (SCL2) program by the Department for BHDIDD, the payment rate for Day Training was reduced from $10.00 to $8.80 per hour (a 12% decrease) and the rate for Supported Employment services was raised from $22.16 per hour to $41.00 per hour (an 85% increase). The apparent purpose of these rate adjustments was to increase the number of SCL participants who receive supported employment services.

Despite this effort it is apparent that participation in Supported Employment has remained largely stagnant since the implantation of the SCL2 Waiver. According to a recent open records request to the Department for Medicaid Services, when comparing calendar year 2013 to 2014 the number of SCL participants receiving Supported Employment services increased only very slightly by 38 participants from 345 participants to 383. Also, when comparing Adult Day Training/Day Training for the same period, the number of participants grew from 3,802 to 4,443, an increase of 641 participants. As a consequence, waiver recipients are increasing being served in underfunded, overcrowded day programs.

The reduced rate for Day Training services, poses a critical challenge for Kentucky as it seeks to comply the Center for Medicaid Services (CMS) recently published rules on Community Settings. Among CMS' expectations for non-residential settings are: the facilitation of sufficient opportunities to go into the broader community and to interact with the general public.

As Kentucky endeavors to implement the new CMS Community settings rule, day Training service providers will no doubt find it most difficult to facilitate more opportunities for interaction with the general public and provide broader programmatic choice, as per CMS's new Community Setting Rule, as a consequence of the 12% rate cute.

Accordingly KACES respectfully requests that the rates for Day Training services be reconsidered/restored."

Shannon McCracken, Interim Executive Director, Kentucky Association of Private Providers; Brittany Knoth, Executive Director Path Forward of KY;
Robert J. Illback, PsyD, ABPP, President and Chief Executive Officer of REACH of Louisville; Stephen S. Zaricki, MSW, Executive Director Community Living, Inc.;
David Coons Family Home Provider; Meghen Wilson Growing Minds Learning Center;
Jenifer C. Frommeyer, Executive Director Dreams With Wings; Leah F. Campbell, JD, Chief Operating Officer Apple Patch Community; Tomika H. Cosby, Executive Director Kentucky Case Management; Steve Frommeyer, Parent of a recipient of waiver services; Leigh Denniston of Almcare; Diane Quarles-Hartman, BS/MHA, Executive Director, Evergreen Life Services; Pamela J. Millay, R.N., J.D, Clinical Director/CPO Redwood; Myra Gribbins, Owner/Executive Director Reach for the stars Case Management; and Brad Schneider Vice President, Developmental Services Division LifeSkills, Inc. stated the following:

"Our 2013 comments said: KAPP strongly supports the development and pursuit of meaningful paid employment for participants, and increasing the opportunities for true integration into their community. However, providers are concerned that service choices are being limited and even eliminated in some cases. Day Training is the most widely utilized service in the waiver currently. Again, people who do not want to work or are of retirement age constitute a large segment of the SCL population, and could struggle with where they "fit" within the new service menu.

We addressed the negative effect of rate reduction in this way: The reduction of Day Training rate from $3 off site and $2.50 on site to a flat rate of $2.20 per unit may be intended to discourage this service option, that it COULD HAVE AN UNINTENDED EFFECT. Providers could resort to higher staff to participant ratios in order to manage labor costs and other expenses. This would likely result in less intensive supervision and a decrease in quality of supports.
We take no satisfaction in having been right in this prediction. The real losers in this scenario have been the participants and the direct support staff in these overcrowded, understaffed and underfunded day centers, in which almost every person in the waiver, over 4,000 are at this very moment.

KAPP's request for the past 2 years has been to reinstate the Day Training rates. The majority of participants still need this service. Reducing the rate did not reduce the need, it reduced the quality.

Although NOT the intention of the waiver, on paper it appears to be a compliant and progressive regulation, Kentucky's resistance to remove barriers to the KEY services for a meaningful day and true community access has resulted in fewer choices. Additionally, the cut in the rates by 15% of those programs has resulted in lower quality, higher staff to participant ratios and fewer opportunities for community inclusion."

Shannon McCracken, Interim Executive Director, Kentucky Association of Private Providers; Brittany Knoth, Executive Director Path Forward of KY;
Robert J. Illback, PsyD, ABPP, President and Chief Executive Officer of REACH of Louisville; Stephen S. Zaricki, MSW, Executive Director Community Living, Inc.;
David Coons Family Home Provider; Meghen Wilson Growing Minds Learning Center;
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“Day Training SCL 1 rates were $12 for community based and $10 for onsite/per hour. Prior to SCL2, many providers conducted DT activities in the community. For a program that conducted 2/3 of the training activities off---site, the actual reduction would be 27.5%. Both rates were reduced to $8.80/hour. The inevitable result has been reductions in staffing, charging individuals for activities fees, and in some instances program closures. The most devastating result has been the need to curtail community activities. The net effect was completely antithetical to the desire for greater community involvement, just as providers warned at the time the regulation was written. At the current and proposed levels, Day Training is an overused, overcrowded model that is unsustainable.

The rate reduction in Day Training was justified in the waiver (which guaranteed that no individual would lose services) and to the provider community with the assurance that Community Access would be available to all and would be a viable alternative means to fund community based training activities. That has not happened and it never will, so in reality people are losing services and Kentucky is on a path of failing to comply with the CMS Final Rule.”

(b) Response: Although the number of participants in day training has increased when considering the overall increase in waiver participants and enrollment in day training the percentage of waiver participants utilizing day training has decreased from 90% in 2013 to 87% in 2015.

(a) Comment: Shannon McCracken, Interim Executive Director, Kentucky Association of Private Providers; Brittany Knoth, Executive Director Path Forward of KY;
Robert J. Illback, PsyD, ABPP, President and Chief Executive Officer of REACH of Louisville; Stephen S. Zaricki, MSW, Executive Director Community Living, Inc.;
David Coons Family Home Provider; Meghen Wilson Growing Minds Learning Center;
Jenifer C. Frommeyer, Executive Director Dreams With Wings; Leah F. Campbell, JD, Chief Operating Officer Apple Patch Community; Tomika H. Cosby, Executive Director Kentucky Case Management; Steve Frommeyer, Parent of a recipient of waiver services; Leigh Denniston of Almcare; Diane Quarles-Hartman, BS/MHA, Executive

Director, Evergreen Life Services; Pamela J. Millay, R.N., J.D, Clinical Director/CPO Redwood; Myra Gribbins, Owner/Executive Director Reach for the stars Case Management; and Brad Schneider Vice President, Developmental Services Division LifeSkills, Inc. stated the following:

“Day Training is a service that most providers would like to see decreasing instead of increasing. After decades of experience in the field, providers believe this service still holds a valuable place in the service arena. Not every person wants a job and we have an aging population that needs to remain active but not necessarily employed. With adequate reimbursement Day Training can be a viable bridge to the community. With adequate reimbursement we can provide one to one or small group opportunities in the community, which would lead to community involvement and inclusion, as the CMS Final Rule intends.

KAPP requests that day training rates be restored to a level that can support those who have no desire to have a job, work part---time and for those who are aging and no longer desire employment. All persons deserve quality supports. One size does not fit all. Our waiver needs to be written to address everyone’s needs and be flexible enough to serve the entire spectrum of people we support.”

(b) Response: Community access is available to all waiver participants. It is not necessarily expected that a participant would achieve total independence within a natural setting within six months. However, within the six-month prior authorized period concrete objectives specified in the plan should have been accomplished. If additional supports are needed to advance the person’s ultimate outcome, they may be requested through a plan modification.

The expectation is that careful and deliberate person centered planning will result in supports that will result in customized supports tailored to the specific needs and desires of the person involved. This will vary immensely from person to person and may include paid or unpaid supports.

Community access services are designed to enable people to have increased access to community resources and offer opportunities for people to develop personal social networks by building friendships and making connections with other people in their local communities.

Impact services, such as community access, are expected to have a significant effect on a person’s ability to engage with other people in the local community. Prior authorizations for this service are limited to up to six months per request; however, should the person require ongoing community access service beyond a six month prior authorization, the person centered team may request ongoing services based on the person’s ongoing need for assistance to connect with community members.

The service provision should decrease as the person develops the skills needed to maintain the connection within the community. Other SCL services, such as day

training and residential services, should be utilized if needed when community access services are withdrawn to assist the person with any additional needs such as personal care, financial management, or transportation.

(18) Subject: Regulatory Impact Analysis

(a) Comment: Jean M Russell, Vice President, Developmental Services, Seven Counties Services, stated the following:

“This document indicates there are not any additional costs imposed on providers through these regulatory changes. We would request a copy of the analysis done to support this statement. As stated previously, the implementation of the MWMA portal has had a significant financial impact on all providers because of the amount of duplication of effort required.”

(b) Response: DMS is implementing the MWMA portal in concert with the Kentucky Office of the Health Benefit and Information Exchange (KOHBIE) to automate and streamline processes associated with home and community based waiver programs. Currently the processes include a combination of manual, paper-based, and automated systems but the MWMA portal will standardize and streamline the processes and tools that support the home and community bases waiver programs. DMS believes that in the long term the MWMA portal will prove to be cost effective for providers.

Additionally, DMS believes that MWMA will improve care coordination and delivery of services to individuals and their families as well expedite processes and actions and allow for information to be preserved and updated much easier online where it is also readily accessible to the appropriate parties.

(19) Subject: Participants under Eighteen Enrollment

(a) Comment: William S. Dolan, Staff Attorney Supervisor, Protection and Advocacy, made the following comment:

“Section 2 concerns participant enrollment. Will the Cabinet use a separate eligibility evaluation tool for children (applicants under age 18)?

(b) Response: No, the cabinet will not be using a separate eligibility evaluation tool for children.

(20) Subject: Behavior Supports

(a) Comment: William S. Dolan, Staff Attorney Supervisor, Protection and Advocacy, made the following comment:

“Section 4 (7) (d) addresses positive behavior support plans for participants with a diagnosis of mental illness and a diagnosis of an intellectual disability.

Please clarify if all participants who are dually diagnosed must have a behavior support plan (BSP). We recommend that the need and development of a BSP be driven by the participant's person-centered team rather than a regulatory mandate."

Christopher D. George, M.Ed., BCBA, LBA, Owner/Executive Director Applied Behavioral Advancements, LLC, made the following comment:

"In the same CCT section of the regulation, new language is written that states (d)1. For a participant who has a diagnosis of mental illness and a diagnosis of an intellectual disability, incorporate a positive behavior support plan that utilizes evidenced-based best practice regarding treatment of the behavioral health condition.

2. In this instance, the behavioral health condition shall be considered the primary support service, with behavioral interventions as supplemental services as needed.

3. The positive behavior support plan shall use both behavioral health and positive behavior supports in a collaborative manner.

This language does two things. First requiring a behavior support plan for someone based upon diagnosis, and not observable symptoms of either a mental illness or an intellectual disability. Secondly it regulatory states that the behavioral health condition is primary

- The determination of the need for a service and which condition is primary should be based upon observable symptoms and not by diagnosis alone. This should be completed by a qualified clinician and not simply regulatory required.
- Requiring a PBSP may not be the appropriate modality for a mental health treatment plan. In other waivers as well as other models (i.e. facility, outpatient services, crisis intervention services) treatment of mental illness and behavioral difficulties are separate functions and not combined into one document.

Based upon the above, will the Cabinet separate psychological services and behavioral services back into the language contained in SCL1? Will the Cabinet then outline specific guidelines for each service based upon the specific discipline and best practices for their discipline?

If the Cabinet will not change the overall service definition, will they change wording in this section of the regulation that specifies that the Person Centered Team with the clinician will determine which behavioral health condition is primary and which interventions will be supplemental support services?"

(b) Response: Thank you for your comments. DMS will be filing an "amended after comments" regulation with the Legislative Research Commission that will remove the language in question (displayed below).

"~~(d) For a participant who has a diagnosis of mental illness and a diagnosis of an intellectual disability, incorporate a positive behavior support plan that utilizes evidenced-based best practice regarding treatment of the behavioral health condition.~~
~~1. In this instance, the behavioral health condition shall be considered the primary support service, with behavioral interventions as supplemental services as needed.~~
~~2. The positive behavior support plan shall use both behavioral health and positive behavior supports in a collaborative manner.~~
~~3. The positive behavior support plan shall be revised whenever necessary by the participant's person-centered team based upon the participant's needs or recommendations from the local Behavior Intervention Committee or the local Human Rights Committee.~~
~~4. Revisions to the positive behavior support plan shall be covered as a consultative clinical and therapeutic service~~]."

(21) Subject: Consultative Clinical and Therapeutic Services

(a) Comment: Christopher D. George, M.Ed., BCBA, LBA, Owner/Executive Director Applied Behavioral Advancements, LLC, made the following comment:

"Section 4 of this proposed regulation, consultative clinical and therapeutic services are described. This service is not new to this amendment but were included in the previous regulation. This service combined Psychological Services and Behavior Supports from the previous SCL regulation. While the goals of streamlining therapeutic services seemed like a positive change, this service delivery model has resulted in the following:

- Confusion on the part of the Person Centered Team as to which part of this service would be most effective.
- Insufficient units for a participant whose may choose to have more than one service.
- If a participant chooses more than one service (i.e. behavior support and counseling), the team is almost always moving towards an exceptional support request even when the total amount of units is not exceptional for someone who sees both a counselor and needs behavior support.
- The regulation is very specific about the need for a Functional Assessment and positive behavior support plan, however these are documents central to behavior support which is only one third of the disciplines lumped into this service heading.
- Clients with the most difficult challenging behaviors are having increased difficulty in finding residential and ADT options as agencies often do not feel that thy can get the clinical support they need through the current caps on the services.
- This service title is not consistent with similar services in other Kentucky Medicaid Waivers (MPW, ABI). This causes confusion for clinicians who may be providing services in more than one waiver, and many clinicians are choosing to move away from SCL clients due to the difficulty in providing an effective service given the service definitions and cap on units.

Given the points above, will the Cabinet consider returning to the service definitions for

Psychological and Behavior Support Services that were part of the previous SCL waiver commonly referred to as SCL 1? By doing so, this would allow these services to return to a service delivery system that was never viewed by participants, agencies, or clinicians as being broken, would help to bring service definitions in line with other waivers, and avoid the exceptional support process (which is draining on both the Cabinet and agency resources).

If the Cabinet will not return to the service definitions contained in SCL1, would the Cabinet raise the cap on CCT units from 160 to 320? This is double the current units and would allow for a participant to easily receive more than one CCT service without necessitating an exceptional support request within their POC year."

(b) Response: Units required above the 160 limit may be requested the exceptional support option. The intent of these changes was to put more focus on an integrated person centered team which includes participation by all service providers. Kentucky is fortunate to have exceptional supports available when extraordinary circumstances related to the assessed needs of a person are indicated.

The information that is requested by the department has demonstrated the capability of identifying extraordinarily high levels of support needs which has resulted in a 71.87% approval rate. The department recognizes the efforts that are put forth on behalf of the citizens.

Partners in the provider community should be commended for the professional manner in which they gathered and organized information which allows for dialogue, focused planning, and a clear path of interventions that is witnessed in the improvement of the citizens' daily lives. In fact, to date, the data shows that 82% of the persons approved for exceptional supports did not have additional requests for supports.

The exceptional support needs identified through the robust assessment process meet a specific intent. These supports would not become an indefinite part of a person's support plan; however, these supports may come and go throughout a person's life on an as-needed basis. The data strongly suggests that this is occurring.

The SCL2 placed a limit on the benefit for consultative clinical and therapeutic services to 160 units per year. We are challenged with providing quality support with finite resources to waiver recipients. The 160 units per year are not a mandatory end of these supports. If supports are needed and necessary, exceptional support requests can be submitted.

From January 1, 2014, through September 28, 2015, claims data would suggest an average number (1,666) of persons received consultative clinical and therapeutic services in SCL2. Of this number, the department received and approved 35 unique requests for consultative clinical and therapeutic services when the services were exhausted. In addition, the department received another 22 requests for consultative clinical and therapeutic services which were denied. The primary reason for 90% of

these denials is because the SCL2 benefits for consultative clinical and therapeutic services were found to be sufficient to meet the needs of the person. The team was asked to resubmit if, and when, the unit limit would be exhausted in 30 days. As such, we have 37 unique requests for exceptional supports from a potential of 1,666. Partners in the community have stepped up and focused their attention and efforts to provide quality supports within the limits of SCL2.

(a) Comment: Christopher D. George, M.Ed., BCBA, LBA, Owner/Executive Director Applied Behavioral Advancements, LLC, made the following comment:

“In this same section, the regulation reads: 4. The positive behavior support plan shall be revised whenever necessary by the participant’s person-centered team based upon the participant’s needs or recommendations from the local Behavior Intervention Committee or the local Human Rights Committee.
Will the Cabinet change the wording to ‘…shall be revised whenever necessary by the clinician based upon the participant’s needs…’?”

(b) Response: The participant and the person-centered planning team should be involved in all decisions regarding supports.

(a) Comment: Lili S. Lutgens, JD, LCSW Therapeutic Intervention Services, PLLC, made the following comment:

“Proposed regulation 907 KAR 12:010 states that a Positive Behavior Support Plan is to be amended "whenever necessary by the participant's person-centered team based upon the participant's needs or recommendations from the local Behavior Intervention Committee or the local Human Rights Committee." pg.17 lines 9-12. The regulation further states that any revisions made to a client's Positive Behavior Support Plan are to be paid for by Consultative Clinical and Therapeutic Support (CCTS) units in lieu of a request for a Positive Behavior Support payment. pg.17 lines 13 - 14.

We are concerned that the proposed regulation takes away from the Positive Behavior Support clinician the authority to determine when a plan is in need of amendment and instead gives the authority to make this determination to the participant's Person Centered Team.

It takes a clinical background to understand whether changes are needed to a plan. It is not unusual, for example, for lay individuals working with a participant to identify for change behaviors that are really "junk behaviors" meaning behaviors that they may not like but which in actuality are not destructive or damaging in any way to the client or those around him. Taking away the clinician's ability to make the determination when a plan should be amended increases the risk that unnecessary or inappropriate requests for plan changes will be made.

In addition, when a clinician determines that a plan needs to be amended, there is often a need to make the change and get approval of the BIC (even if only on an emergency

basis) in an expedient fashion especially where a new potentially dangerous behavior emerges. If, for example, a participant with a behavior plan suddenly engages in eloping for the first time, the plan needs to be amended and staff trained ASAP. Requiring approval of the Person Centered Team will slow down this process increasing the chances that something will happen to the participant while the team awaits a change to their plan much less training under the plan.

As for the reduction of units, we are concerned that this will further stretch already insufficient units. Per the prior amendment, participants receive 160 units per year or 13.33 units per month of CCTS services to be shared by the participant's Positive Behavior Support Specialist, Psychologist, and/or Nutritionist. We are finding that in cases where the units must be shared, they are typically insufficient to meet the client's needs resulting in the need to request exceptional supports. Even where the units are not shared, for clients of high acuity, the units again are not sufficient.

If the Positive Behavior Support Specialist must use CCTS units to revise the plan, this will mean months in which the plan is revised but no other services can take place such as training, monitoring, or observation. Clients will go without the services that they need to remain stable in the community.

(b) Response: Kentucky is fortunate to have exceptional supports available when extraordinary circumstances related to the assessed needs of a person are indicated. The information that is requested by DMS has demonstrated the capability of identifying extraordinarily high levels of support needs which has resulted in a 71.87% approval rate.

DMS recognizes the efforts that are put forth on behalf of the citizens. Partners in the provider community should be commended for the professional manner in which they gathered and organized information which allows for dialogue, focused planning, and a clear path of interventions that is witnessed in the improvement of the citizens' daily lives. In fact, to date, the data shows that 82% of the persons approved for exceptional supports did not have additional requests for supports.

The exceptional support needs identified through the robust assessment process meet a specific intent. These supports would not become an indefinite part of a person's support plan; however, these supports may come and go throughout a person's life on an as-needed basis. The data strongly suggests that this is occurring. The SCL2 placed a limit on the benefit for consultative clinical and therapeutic services to 160 units per year. We are challenged with providing quality support with finite resources to waiver recipients. The 160 units per year are not a mandatory end of these supports. If supports are needed and necessary, exceptional support requests can be submitted.

From January 1, 2014, through September 28, 2015, claims data would suggest an average number (1,666) of persons received consultative clinical and therapeutic services in SCL2. Of this number, the department received and approved 35 unique requests for consultative clinical and therapeutic services when the services were

exhausted. In addition, the department received another 22 requests for consultative clinical and therapeutic services which were denied. The primary reason for 90% of these denials is because the SCL2 benefits for consultative clinical and therapeutic services were found to be sufficient to meet the needs of the person. The team was asked to resubmit if, and when, the unit limit would be exhausted in 30 days. As such, we have 37 unique requests for exceptional supports from a potential of 1,666. Partners in the community have stepped up and focused their attention and efforts to provide quality supports within the limits of SCL2.

(a) Comment: Lili S. Lutgens, JD, LCSW Therapeutic Intervention Services, PLLC, made the following comment:

“With the withdrawal of speech therapy, physical therapy, and occupational therapy from the SCL program, we respectfully suggest that the Cabinet consider offsetting the change in the proposed version of 12:010 to require amendments to the plan to come from CCTS units by increasing the allotment of units for CCTS services to 240 per year or 20 per month. This will enable Positive Behavior Support Specialists to revise plans as needed in order to make sure that they remain relevant to the client's needs while also providing units for additional services (such as training) in any given month. 20 units a month will also help reduce the number of cases in which exceptional supports are requested.”

Christopher D. George, M.Ed., BCBA, LBA owner and Executive Director of Applied Behavioral Advancements, made the following comment:

“In looking at the overall 160, I would recommend and I support what Lili stated as far as the increase in the number of units. Certainly, the increase in the number of units would be one that would help us to avoid the costly - and costly both to us as providers but costly to the Cabinet as well -- process of exceptional supports and being able to move through that.

There’s a lot of time and energy that is wasted on both sides of the fence that does not need to be because the system in place should be able to allow for 240, 260 units to be observed and monitored by the Quality Administrators that are in place and to ensure that there’s been a proper ethical usage of those taxpayer dollars. A cap has not benefitted the individual. It has only helped to reduce costs, and that’s not why we’re here. So, I do recommend that.”

Therapeutic Intervention Services, PLLC, made the following comment:

“Section 4.7 Recommend monies budgeted for Speech, Occupational, and Physical Therapies, which were removed from the waiver, be added to increasing the limit of Consultative and Clinical Therapies from 160 units per year to 240 units per year (average of 20 units per month). This change would minimize the number of exceptional supports requests.”

Shannon McCracken, Interim Executive Director, Kentucky Association of Private Providers; Brittany Knoth, Executive Director Path Forward of KY;
Robert J. Illback, PsyD, ABPP, President and Chief Executive Officer of REACH of Louisville; Stephen S. Zaricki, MSW, Executive Director Community Living, Inc.;
David Coons Family Home Provider; Meghen Wilson Growing Minds Learning Center;
Jenifer C. Frommeyer, Executive Director Dreams With Wings; Leah F. Campbell, JD, Chief Operating Officer Apple Patch Community; Tomika H. Cosby, Executive Director Kentucky Case Management; Steve Frommeyer, Parent of a recipient of waiver services; Leigh Denniston of Almcare; Diane Quarles-Hartman, BS/MHA, Executive Director, Evergreen Life Services; Pamela J. Millay, R.N., J.D, Clinical Director/CPO Redwood; Myra Gribbins, Owner/Executive Director Reach for the stars Case Management; and Brad Schneider Vice President, Developmental Services Division LifeSkills, Inc. stated the following:

“Recommend that monies allocated for speech, Occupational and Physical therapies, which were removed from the waiver, be added to increasing the limit of Consultative and Clinical Therapies from 160 units per year to 240 units per year (average of 20 units per month.) This change would reduce the number of exceptional support requests.”

(b) Response: DMS is not reducing coverage of therapies as waiver participants who previously/currently receive them as a waiver program benefit will be able to receive them as a state plan benefit. Thus, though DMS expenditures on therapies as a waiver benefit will drop DMS expenditures on therapies as a state plan benefit will increase proportionately.

(a) Comment: Shannon McCracken, Interim Executive Director, Kentucky Association of Private Providers; Brittany Knoth, Executive Director Path Forward of KY;
Robert J. Illback, PsyD, ABPP, President and Chief Executive Officer of REACH of Louisville; Stephen S. Zaricki, MSW, Executive Director Community Living, Inc.;
David Coons Family Home Provider; Meghen Wilson Growing Minds Learning Center;
Jenifer C. Frommeyer, Executive Director Dreams With Wings; Leah F. Campbell, JD, Chief Operating Officer Apple Patch Community; Tomika H. Cosby, Executive Director Kentucky Case Management; Steve Frommeyer, Parent of a recipient of waiver services; Leigh Denniston of Almcare; Diane Quarles-Hartman, BS/MHA, Executive Director, Evergreen Life Services; Pamela J. Millay, R.N., J.D, Clinical Director/CPO Redwood; Myra Gribbins, Owner/Executive Director Reach for the stars Case Management; and Brad Schneider Vice President, Developmental Services Division LifeSkills, Inc. stated the following:

“Consultative Clinical and Therapeutic Services have an annual limit of 160 units per plan year. This does not begin to cover the needs of participants with extreme behavioral needs. Please consider increasing the limit. Recommend that units be restored to SCL 1 levels. Behavior IS a major barrier to community integration and employment.”

Christopher D. George, M.Ed., BCBA, LBA owner and Executive Director of Applied

Behavioral Advancements stated the following:

"Going back many years, I participated with the Cabinet in the discussion prior to the implementation of the current regulation and the CCT model. There was a lot of discussion regarding the combining of psychology, behavior analysis, dietary under one heading, and then being able to utilize those services as possible. On the table, it sounded great. With a cap of 160 per year, not so great. But, certainly, as an agency, we have worked. And as an agency, we serve over 357 individuals across the state. I have approximately close to 80 clinicians; 75% of whom are behavioral clinicians. And, so, we have sought to work within those confines. What we've found is that the number of units is insufficient to provide appropriate training to residential agencies that may be requesting it, to day programs that may be requesting it, and to provide an appropriate monitoring to determine that the plan is being effectively followed. There simply just aren't enough hours. If you take the 160 and divide that out, you have approximately 45 minutes per week to ensure that a plan is being accurately implemented as well as providing competency-based training to the direct support professionals who are implementing that plan. It simply is not sufficient. What we have found is that with the combination between psychology and behavior supports, the individuals who need the greatest amount of support within this Waiver, those that may have significant challenging behaviors and a dual diagnosis of some sort of mental illness are the ones that suffer the most. They have to use and combine between two separate disciplines with 160 units per year."

(b) Response: Kentucky is fortunate to have exceptional supports available when extraordinary circumstances related to the assessed needs of a person are indicated. Units required above the 160 limit may be requested through exceptional supports. The information that is requested by DMS has demonstrated the capability of identifying extraordinarily high levels of support needs which has resulted in a 71.87% approval rate. DMS recognizes the efforts that are put forth on behalf of the citizens. Partners in the provider community should be commended for the professional manner in which they gathered and organized information which allows for dialogue, focused planning, and a clear path of interventions that is witnessed in the improvement of the citizens' daily lives. In fact, to date, the data shows that 82% of the persons approved for exceptional supports did not have additional requests for supports.

The exceptional support needs identified through the robust assessment process meet a specific intent. These supports would not become an indefinite part of a person's support plan; however, these supports may come and go throughout a person's life on an as-needed basis. The data strongly suggests that this is occurring. The SCL2 placed a limit on the benefit for consultative clinical and therapeutic services to 160 units per year. We are challenged with providing quality support with finite resources to waiver recipients. The 160 units per year are not a mandatory end of these supports. If supports are needed and necessary, exceptional support requests can be submitted.

From January 1, 2014, through September 28, 2015, claims data would suggest an average number (1,666) of persons received consultative clinical and therapeutic

services in SCL2. Of this number, the department received and approved 35 unique requests for consultative clinical and therapeutic services when the services were exhausted. In addition, the department received another 22 requests for consultative clinical and therapeutic services which were denied. The primary reason for 90% of these denials is because the SCL2 benefits for consultative clinical and therapeutic services were found to be sufficient to meet the needs of the person. The team was asked to resubmit if, and when, the unit limit would be exhausted in 30 days. As such, we have 37 unique requests for exceptional supports from a potential of 1,666. Partners in the community have stepped up and focused their attention and efforts to provide quality supports within the limits of SCL2.

(22) Subject: Exceptional Supports

(a) Comment: Christopher D. George, M.Ed., BCBA, LBA, Owner/Executive Director Applied Behavioral Advancements, LLC, made the following comment:

"The current regulation amendment does not specify anything about the exceptional rate protocol. This was previously contained in the SCL Policy Manual and incorporated into the regulation by reference.
Will the Cabinet write in specific information about the exceptional support supports and a specific protocol into this amended regulation?"

(b) Response: The exceptional support protocol is incorporated by reference and can be found here: http://www.chfs.ky.gov/dms/incorporated.htm#12.

(a) Comment: Christopher D. George, M.Ed., BCBA, LBA, Owner/Executive Director Applied Behavioral Advancements, LLC, made the following comment:

"The exceptional support process for the past year has been primarily a paper based decision. This does not appear to be in line with the vision of the Cabinet in having a person centered process for determining services. It seems that meeting with the participant and their team as part of the decision making process would be necessary to be truly person centered.

As part of the exceptional support protocol, will the Cabinet write in language requiring that a member of that committee, meet the participant as part of the decision making process?"

(b) Response: The person centered planning team should accurately represent the needs and desires of the participant and present a description of the support that will be provided if the exceptional support is approved.

(a) Comment: Shannon McCracken, Interim Executive Director, Kentucky Association of Private Providers; Brittany Knoth, Executive Director Path Forward of KY;
Robert J. Illback, PsyD, ABPP, President and Chief Executive Officer of REACH of Louisville; Stephen S. Zaricki, MSW, Executive Director Community Living, Inc.;

David Coons Family Home Provider; Meghen Wilson Growing Minds Learning Center; Jenifer C. Frommeyer, Executive Director Dreams With Wings; Leah F. Campbell, JD, Chief Operating Officer Apple Patch Community; Tomika H. Cosby, Executive Director Kentucky Case Management; Steve Frommeyer, Parent of a recipient of waiver services; Leigh Denniston of Almcare; Diane Quarles-Hartman, BS/MHA, Executive Director, Evergreen Life Services; Pamela J. Millay, R.N., J.D, Clinical Director/CPO Redwood; Myra Gribbins, Owner/Executive Director Reach for the stars Case Management; and Brad Schneider Vice President, Developmental Services Division LifeSkills, Inc. stated the following:

"KAPP's comments in 2013 on the Exceptional Rate Protocol were minimal, as we were assured time again that this would be the answer for any limit caps, rate reductions, discontinuation of the NC Snap High Intensity funding for some participants, etc. It was an untested process and we had no choice but to see how it worked out. Our one comment was this: KAPP requests a clarification on the specific process for request and approval.

In reality, the process has been confusing and frustrating at best.

While it is acknowledged that the Exceptional Rate Protocol may be an attempt to rectify this problem, it is a fundamentally flawed approach. For example, the Exceptional Rate approval process is time---consuming and complicated and there is no process for emergency approvals. It requires that any proposal that is submitted be to fund new, time---limited initiatives and cannot be used to provide necessary supports (e.g. 1:1 staff support) that have already been put into place for health or safety reasons. Many people experience behavior, mental health or medical crises, necessitating the provision of intensified supports in order to keep them safe and in many cases, these services are required for long periods of time. The proposed protocol does not take these situations into account so it fails to solve the problem of cost of service inequity. In addition, neither the reimbursement structure nor the Exceptional Rate Protocol take into account the fact that the population served is aging, leading to increased costs, trending upwards over time. In short, the proposed regulation is at best a short---term fix, when a long---term approach is warranted. Kentucky's I/DD population would be better served if an entirely new rate structure – tied to individual support needs – were implemented in place of the Exceptional Rate Protocol.

We've been told the Exceptional Rate Fund has no budget. Do the funds come from future slot allocations, the ones that are approved?

We are often told to call the Comp Cares for crisis supports before requesting Exceptional Rates. Our understanding is that those monies are from the State General Fund, as well…the same pot as the Exceptional Rate money?

Many participants in need of additional supports and funding (LONG TERM) were people who successfully transition out of ICF's through Money Follows the Person. Many of those participants were considered difficult to support in that setting at 4-5

times the reimbursement rates. Now we are serving them in the community at reduced rates, service unit caps and with a difficult if not impossible way to get support to keep them safe and in their community.

Participants in crisis can end up in prison, homeless shelters, court ordered out of their homes and communities, before Exceptional Supports can be secured in some cases. To add insult to injury, when searching for new service providers for these participants, often no one is willing to take a chance on the person because they don't want to inherit this difficult situation. Additionally, providers are increasingly denying referrals from ICF's because they feel they will not be able to support the person due to the absence of true crisis services and no assurance of getting Exceptional Rate Supports beyond the initial transition. The process is so burdensome; many providers would rather not even try.

It should be noted that the Exceptional Rate request process lies in the hands of the case managers. Yes, this is part of their job, but it is difficult, time consuming and they are not incentivized to ensure the process occurs. Case Management spends additional hours and days on these cases and has no opportunity for enhanced rate for those services.

There should be a process for emergency approval. The approval should backdate to the request to ensure service occurs when needed. This is something the person centered team and conflict---free case manager should decide and monitor responsibly. With the discontinuation of both the enhanced rate for participants assessed as high---intensity (in SCL 1) and the Money Follows the Person waiver, the Exceptional Rate Protocol was the promise to providers for the continued safe support of participants with exceptional needs (medical, behavioral, etc.) This promise has not been fulfilled. Providers are told there is no budget for this and the request process is laborious and difficult. The waiver application predicted (based upon data) that approximately 8% of the waiver population would need Exceptional Rate supports, however only 3---4% have been approved for it. The protocol has no "protocol". Support teams need a clearly defined process for what is appropriate to request, how to request it and a timely process for approval."

(b) Response: The request for exceptional supports is either for a unit rate increase or a unit increase. The goal of the exceptional support team is to deliver a resolution within 14 business days. In reviewing the data and calculating turnaround time in both business days and calendar days our data does show the average business days as 10.3 days and the average calendar days as 13.07. The total number of service requests was 302 (89% of all service requests). To be able to reach a decision the information that was submitted was responsive and further documentation was not necessary.

A second group of requests, which totaled 36 (11% service requests), did need additional information before a decision was made as the information was incomplete and non-responsive. When the information that was requested was received, the

average business days' turnaround time was 3.89 days while the average calendar days was 3.94 days. 89% of the service requests would indicate a clear understanding of the exceptional supports protocol. With our average turnaround time, the system is set up to result in no service gaps. This is well seen in the 89% of the service requests when partners in the provider community provide responsive and complete information for review. The data would suggest that with this support the system in place is an emergency oriented culture.

Kentucky is fortunate to have exceptional supports available when extraordinary circumstances related to the assessed needs of a person are indicated. The information that is requested by the department has demonstrated the capability of identifying extraordinarily high levels of support needs which has resulted in a 71.87% approval rate. The department recognizes the efforts that are put forth on behalf of citizens.

The provider community should be commended for the professional manner in which they gathered and organized information which allows for dialogue, focused planning, and a clear path of interventions that is witnessed in the improvement of peoples' daily lives. In fact, to date, the data shows that 82% of the persons approved for exceptional supports did not have additional requests for supports. The exceptional support needs identified through the robust assessment process meet a specific intent. These supports would not become an indefinite part of a person's support plan; however, these supports may come and go throughout a person's life on an as-needed basis. The data strongly suggests that this is occurring.

We presently have 4650 persons enrolled in the SCL program. The exceptional support committee has issued 160 decisions which reflect 3.4% of the population was identified as potentially needing exceptional supports. The prime driver of recognizing possible situations where exceptional supports might be necessary comes from the network providers. The data would suggest that the providers only identified a total of 3.4% of the population in need of exceptional support review. It is also outstanding that 89% of the service requests were submitted without any problems and were clearly in compliance with what was needed to make a decision.

(a) Comment: Shannon McCracken, Interim Executive Director, Kentucky Association of Private Providers; Brittany Knoth, Executive Director Path Forward of KY; Robert J. Illback, PsyD, ABPP, President and Chief Executive Officer of REACH of Louisville; Stephen S. Zaricki, MSW, Executive Director Community Living, Inc.; David Coons Family Home Provider; Meghen Wilson Growing Minds Learning Center; Jenifer C. Frommeyer, Executive Director Dreams With Wings; Leah F. Campbell, JD, Chief Operating Officer Apple Patch Community; Tomika H. Cosby, Executive Director Kentucky Case Management; Steve Frommeyer, Parent of a recipient of waiver services; Leigh Denniston of Almcare; Diane Quarles-Hartman, BS/MHA, Executive Director, Evergreen Life Services; Pamela J. Millay, R.N., J.D, Clinical Director/CPO Redwood; Myra Gribbins, Owner/Executive Director Reach for the stars Case Management; and Brad Schneider Vice President, Developmental Services Division LifeSkills, Inc. stated the following:

“The process of getting approval for exceptional supports is not clear. Many providers have their requests denied. The process is laborious and lengthy. There is no provision for emergency approval and the crisis at hand usually worsens while waiting for an answer on the exceptional support request. Only select services are eligible for exceptional support. All should be, including case management, which can require time and resources far beyond what is typically needed to coordinate care for a participant.

The Kentucky Exceptional Supports Protocol: 6.a. Documentation of completion of the expanded requirements for direct support professional (DSP) as appropriate. What does this mean?

6.b. Documentation of the provider’s ability to support people with exceptional behavioral health or behavioral support needs. Does this mean that if the provider does not have a lot of experience in behavior supports the exceptional support request will not be approved?”

Christopher D. George, M.Ed., BCBA, LBA owner and Executive Director of Applied Behavioral Advancements, stated the following:

“What we found in the exceptional support process is that it has been -- and, again, I would like to go back that we would formally request that there be a specific protocol written about what is required regarding documentation. We have done hundreds of exceptional support requests. And guess what? Not a single one has been the same. What has been requested from the case manager and those things, not a single one. My clinicians, we meet every two weeks; and we have a clinical meeting. And they say tell us the format, tell us how you want us to do the exceptional supports. And my only answer has been I don’t know what to tell you because each one is different. And, so, every time that we look at that -- and I would like to see a streamlined process so that we can ensure consistency and continuity over every single individual’s case.”

(b) Response: To date we have not found this a barrier at all and it has not been a factor in any denial for behavioral supports. The documentation of completion of the expanded requirements for direct support professional (DSP) is relevant if an agency identifies the need for more specially trained DSPs in order to provide support to the participant. If this is the case, that information should be included in the exceptional support request.

(a) Comment: Shannon McCracken, Interim Executive Director, Kentucky Association of Private Providers; Brittany Knoth, Executive Director Path Forward of KY; Robert J. Illback, PsyD, ABPP, President and Chief Executive Officer of REACH of Louisville; Stephen S. Zaricki, MSW, Executive Director Community Living, Inc.; David Coons Family Home Provider; Meghen Wilson Growing Minds Learning Center; Jenifer C. Frommeyer, Executive Director Dreams With Wings; Leah F. Campbell, JD, Chief Operating Officer Apple Patch Community; Tomika H. Cosby, Executive Director Kentucky Case Management; Steve Frommeyer, Parent of a recipient of waiver services; Leigh Denniston of Almcare; Diane Quarles-Hartman, BS/MHA, Executive

Director, Evergreen Life Services; Pamela J. Millay, R.N., J.D, Clinical Director/CPO Redwood; Myra Gribbins, Owner/Executive Director Reach for the stars Case Management; and Brad Schneider Vice President, Developmental Services Division LifeSkills, Inc. stated the following:

"There should be a process for emergency approval. The approval should backdate to the request to ensure service occurs when needed. Again, this is something the person centered team and conflict-free case manager should decide and monitor responsibly. Projected 8% of population would need it based upon data; only 3-4% participants have been approved for it."

(b) Response: The request for exceptional supports is either for unit rate increase or a unit increase. The goal of the exceptional support team is to deliver a resolution within 14 business days. In reviewing the data and calculating turnaround time in both business days and calendar days our data does show the average business days as 10.3 days and the average calendar days as 13.07. The total number of service requests was 302 (89% of all service requests). To be able to reach a decision the information that was submitted was responsive and further documentation was not necessary.

A second group of requests, which totaled 36 (11% service requests), did need additional information before a decision was made as the information was incomplete and non-responsive. When the information that was requested was received the average business days' turnaround time was 3.89 days while the average calendar days was 3.94 days.

89% of the service requests would indicate a clear understanding of the exceptional supports protocol. With our average turnaround time, the system is set up to result in no service gaps. This is well seen in the 89% of the service requests when partners in the provider community provide responsive and complete information for review. The data would suggest that with this support the system in place is an emergency oriented culture.

Kentucky is fortunate to have exceptional supports available when extraordinary circumstances related to the assessed needs of a person are indicated. The information that is requested by the department has demonstrated the capability of identifying extraordinarily high levels of support needs which has resulted in a 71.87% approval rate. The department recognizes the efforts that are put forth on behalf of citizens. The provider community should be commended for the professional manner in which they gathered and organized information which allows for dialogue, focused planning, and a clear path of interventions that is witnessed in the improvement of peoples' daily lives. In fact, to date, the data shows that 82% of the persons approved for exceptional supports did not have additional requests for supports. The exceptional support needs identified through the robust assessment process meet a specific intent. These supports would not become an indefinite part of a person's support plan; however, these supports may come and go throughout a person's life on an as-needed basis. The data

strongly suggests that this is occurring.

We presently have 4650 persons enrolled in the SCL program. The exceptional support committee has issued 160 decisions which reflect 3.4% of the population was identified as potentially needing exceptional supports. The prime driver of recognizing possible situations where exceptional supports might be necessary comes from network providers. The data would suggest that the providers only identified a total of 3.4% of the population in need of exceptional support review. It is also outstanding that 89% of the service requests were submitted without any problems and were clearly in compliance with what was needed to make a decision.

(a) Comment: Christopher D. George, M.Ed., BCBA, LBA owner and Executive Director of Applied Behavioral Advancements, made the following comment:

The other thing -- and I would like to just on, I guess, a technical note. The exceptional support protocol is referenced in the reimbursement amendment. However, it is not included in this regulation. And, so, therefore, if my understanding is right, since it's not in the regulation, technically, there's no exceptional supports anymore. So, I would like to see that protocol specifically written into whatever this is -- 12:010, I believe -- with very specific outlines about what shall be turned in. The other thing I'd like to note about the exceptional support process is the lack of person-centeredness for which it is taken. All of the requests are funneled through the case manager, which I understand may be a very efficient way for the Cabinet to receive information and to disseminate information. However, this is not person-centered because we have a case manager that is coming back to a behavior clinician going based upon the documentation or review of the record, there has been a recommendation by the committee for you to do such-and-such and so-and-so with your plan.

There's no clinical discussion with my clinician about the decisions that they've made regarding the treatment of the individual, and all of that is filtering through the case manager. I would like to see that process opened up where we have a direct communication with the committee to be able to discuss; and if there are questions about the services that we provide, why things have not been moving forward and those things so that can be duly noted."

(b) Response: The Exceptional Supports Protocol is not incorporated by reference into 907 KAR 12:010, New supports for community living waiver service and coverage policies; however, it is incorporated by reference into 907 KAR 12:020, Reimbursement for new supports for community living waiver services; thus, it still exists and must be used to request services above the respective service limit.

(a) Comment: Christopher D. George, M.Ed., BCBA, LBA owner and Executive Director of Applied Behavioral Advancements, made the following comment:

"The other thing that I have been, I guess, disappointed with is the fact that there's a strong push by this Cabinet to move towards person-centered, to know the individual, to

know who they are as a person, not just as a piece of paper or a number or a dollar sign. However, our exceptional support process is simply that. It is a paper-shuffling exercise. Many times we are requested -- and I will say that there have been several meetings that we have had where Raymond has been able to join us for a meeting to discuss exceptional supports. However, this is the exception and not the rule. I think that it should be and I would like to see that within the protocol that will be listed in this regulation that a face-to-face visit with the individual, the participant who is in need of exceptional supports, be completed by the Cabinet so that they can put a face along with that person and to know them as a person about why they need those services and the things that they should be doing. That is a move towards the vision of this Cabinet and the things that are clearly stated as far as what we stand for and the people that we serve."

(b) Response: Thank you for your comments. Cabinet employees are not members of person-centered teams. The exceptional support requests typically contain sufficient information in order for cabinet staff to make appropriate decisions regarding requests.

Cabinet staff sees every SCL waiver participant at least once every other year through the Supports Intensity Scale (SIS) assessment process which determines individual support needs. Should the team believe that a person's needs have changed and the support level is impacted there is a process to request another SIS assessment.

(23) Subject: Suggested Cost Controls

(a) Comment: Lili S. Lutgens, JD, LCSW Therapeutic Intervention Services, PLLC, made the following comment:

"We understand that the Cabinet needs to controls costs and we concur that some clinicians are providing services in cases where services are no longer necessary and/or at a frequency above what is necessary based upon the client's current target behaviors. We suggest that in lieu of further reducing the number of units available in all cases that the Cabinet instead focus on better ensuring that there is timely termination of cases when clients are no longer in need of or benefiting from services.

We have several suggestions to this effect.

First, we suggest that the fading plan language in the Positive Behavior Support Plan be further fleshed out so that all members of the Person Centered Team and the SIC know when a plan will be faded and then terminated. Currently the language regarding criteria for fading and termination reads as follows: 'Include specific criteria for fading or discontinuing the service as the participant's adaptive, positive behavior improves.' pg.89 lines 14-15. We propose that this language be strengthened to read as follows: 'Clarify in measurable terms the frequency, intensity, and duration of the target behaviors that will signify a reduction in services is In order as well as the frequency, intensity, and duration of the target behaviors when services are at an end.'

We also propose that the regulation be revised to require 'all plans submitted to the Area BIC for review must include information on the current frequency, intensity and duration of the target behaviors identified in the plan' so that the Area BIC can have some understanding of why services are continuing. We further suggest that 'Area BICS may require the Behavior Support Specialist and Person Centered Team to justify continued services in those cases in which the frequency, intensity, and/or duration of target behaviors is low or where there is no proof that the target behaviors are disruptive to the individual or others.' This will hopefully reduce the continuation of plans and services that are no longer necessary."

(b) Response: DMS is filing an "amended after comments" regulation with the Legislative Research Commission to adopt the recommended language as follows:

"k. Clarify in measurable terms the frequency, intensity, and duration of the target behaviors:
(i) That will signify that a reduction in services is in order; and
(ii) When services are at an end;".

The area BIC or HRC has the authority to request justification for services and this should be encouraged.

(24) Subject: Exclusion of CCTS, PA, CA, and PCC from Termination Language

(a) Comment: Lili S. Lutgens, JD, LCSW Therapeutic Intervention Services, PLLC, made the following comment:

"We further propose that CCTS units as well as Personal Assistance (PA) units, Community Access (CA) units, and Person Centered Coach (PCC) units be excluded from the termination language of 12:010. Currently 12:010 requires any SCL provider choosing to terminate services to "Continue to provide supports until alternative services or another placement is secured." pg.31 lines 7-8. While this makes perfect sense for residential and day treatment programs, this requirement that services continue to be provided until alternative services are secured makes it impossible for therapeutic services including CCTS,PA, CA, and PCCS services to be terminated where they are no longer necessary or beneficial1.

We find that families and sometimes even other SCL providers want to maintain PA, PCC, and especially CCTS and CA services even when all treatment plan goals have been met and there is little else for the clinician to do. In addition,we also find it not uncommon for some participants and families to be chronically non-compliant with treatment plan goals but still expect the clinician to show up and work with the participant.

It is a waste of the State's money to pay for clinicians to provide services where goals have been met simply because the family and/or Person Centered Team is fearful of letting go of services. Likewise, it is a waste of the State's money to pay for services that

are not effective because the participant and/or family is chronically non-compliant. What is clinically needed in cases of non-compliance is to give the participant and/or family sufficient time without services to be uncomfortable with the situation such that they are motivated to do something different at which time services can begin again.

We thus propose that CCTS, PA, CA, and PCC services be excluded from the current termination language such that these services can be terminated where the clinician deems that the service is no longer necessary and/or the participant or family is evidencing a pattern of non-compliance."

(b) Response: There are two separate issues in this request. The current termination language is meant to address provision of services that are necessary but the team has concluded that a change of provider for a specific service is necessary. In this scenario the present provider would continue services until a new provider is determined so that a sound transfer can occur. If the reason for termination is that the support provided is no longer necessary, the provider would go through a termination of services process and once that is completed, close out the service. This scenario does not fall under the current termination language.

The second part of the comment would be covered. Resistance is and always will be present in the therapeutic process. The expectation is that clinicians will identify plans to positively impact the resistance. If it is the judgment of the clinician that he or she cannot be effective it would be ethically prudent to work with the team and to find another provider who may be better suited to provide the service. In this scenario the current termination language is appropriate.

(25) Subject: Payment for Team Meetings and Trainings

(a) Comment: Lili S. Lutgens, JD, LCSW Therapeutic Intervention Services, PLLC, made the following comment:

"Most if not all therapeutic programs allow clinicians to decide when to terminate services including the former Impact Plus program which allowed both the mental health therapists and therapeutic child support specialists working under the program to terminate where goals were met and/or the client and family were non-compliant.

Kentucky's First Steps Program pays clinicians to attend team meetings although the amount of payment is limited to 4 units or one hour per meeting. As a former First Steps social worker, I can say that the team meetings proved invaluable in terms of allowing me to efficiently gather information and to coordinate my care with that of the other therapists working with the client. In the end, with the help of team meetings, clinicians were able to build upon one another's work without duplicating services.

Currently 907 KAR 12:010 does not pay for members of a client's treatment team to attend team meetings. pg.22 line 9. This makes sense for residential providers who,for example, are paid a per diem rate but for CCTS clinicians who are paid for provision of

services on a unit rather than daily rate, this can create a hardship.

Clients with serious behavioral and/or mental health issues are most in need notjust of CCTS services but of team meetings to coordinate care among the various providers. Team meetings are an efficient opportunity for CCTS clinicians to obtain information and offer consultation. Lack of payment becomes a disincentive to attend team meetings and ultimately to treat high acuity clients in need of regular team meetings much less services.

We thus respectfully request that 907 KAR 12:010 be rewritten to allow for payment of attendance at team meetings if the clinician's work is an important part of the meeting, i.e., for meetings that focus on the client's behavior or mental health issues, and at which the behavioral and/or mental health clinician provides clinical consultation to the rest of the team.

Similarly, for clients with behavior plans, 907 KAR 12:010 requires all members of a client's treatment team including their CA, PA, and PCC to be trained on the plan but the regulation does not expressly provide for the CA, PA, or PCC to receive payment for attending behavior plan training. This creates a disincentive for these service providers to take clients with behavior plans. We respectfully request that the Cabinet provide for payment for these individuals to be trained on the client's behavior plan."

(b) Response: There is no payment mechanism for any provider to attend a team meeting. This is considered part of the cost of doing business.

(26) Subject: Positive Behavior Supports

(a) Comment: Lili S. Lutgens, JD, LCSW Therapeutic Intervention Services, PLLC, made the following comment:

"Proposed regulation 907 KAR 12:010 (page 70 lines 2 -8) states that:

1. For a participant who has a diagnosis of mental illness and a diagnosis of an intellectual disability, incorporate a positive behavior support plan that utilizes evidenced-based best practice regarding treatment of the behavioral health condition.
2. In this instance, the behavioral health condition shall be considered the primary support service, with behavioral interventions as supplemental services as needed.
3. The positive behavior support plan shall use both behavioral health and positive behavior supports in a collaborative manner.

The regulation thus appears to require that all individuals with a diagnosis of a mental illness and an intellectual disability have a positive behavior support plan.

There are some cases, however, in which positive behavior support services may not be a good choice of treatment for the client such as in cases of individuals with mild intellectual disabilities with severe mental illnesses such as schizophrenia. In these

cases, positive behavior support services may not be effective but instead mental health treatment is what is needed. In fact, the National Institute of Mental Health (NIMH) recognizes cognitive behavioral therapy (CBT) and psycho-education as appropriate treatment techniques for schizophrenia but makes no mention of behavioral interventions of the type used in positive behavior support plans1

Similarly, for the treatment of bipolar disorder, the NIMH lists CBT, family-focused therapy, interpersonal and social rhythm therapy, and psycho- education as approved treatment techniques and again makes no mention of behavioral interventions.

Requiring in all cases that an individuals with a mental illness and intellectual disability receive positive behavior supports may have the unintentional outcome of imposing upon participants behavioral interventions that have not been approved for the treatment of individuals with their diagnoses. This provision also takes away from the clinician(s) and the person centered team the discretion to decide what is in the best interest of the participant. We respectfully request that the above referenced language be deleted and the discretion of the clinician/person centered team be retained."

1 http://www.nlmh.nlh.gov/health/publications/schlzophrenia/lndex .shtml#pub7

2 http://www.nlmh.nlh.gov/health/toplcs/blpolar disorder/index.shtml#part_ 145406."

Christopher D. George, M.Ed., BCBA, LBA owner and Executive Director of Applied Behavioral Advancements, made the following comment:

"The new regulation proposes that anyone that is diagnosed with both an intellectual disability and a mental illness that within that that there is a requirement to provide a Positive Behavior Support Plan. I would move as a clinician and as a licensed Behavior Analyst that we make decisions based upon who needs a Behavior Support Plan based upon the characteristics, the observable behaviors that they have or the observable symptoms of their mental illness. Simply a requirement based upon a diagnosis is not person-centered. It is not an effective use of the taxpayer money or the Cabinet's purview of practice and their willingness to oversee and regulate what we are doing. This should be based upon the clinical expertise of the clinician and whether that is a licensed psychologist that is looking at their individual counseling needs or if it is the behavior analyst that is making decisions about environmental manipulations and training procedures that we need to train staff on in order to reduce challenging behaviors and allow the individual to be a successful member of the integrated community."

(b) Response: Thank you for your comments. DMS will file an "amended after comment" regulation with the Legislative Research Commission to remove the language in question (displayed below).

"~~(d)1. For a participant who has a diagnosis of mental illness and a diagnosis of an~~

~~intellectual disability, incorporate a positive behavior support plan that utilizes evidenced-based best practice regarding treatment of the behavioral health condition. 2. In this instance, the behavioral health condition shall be considered the primary support service, with behavioral interventions as supplemental services as needed. 3. The positive behavior support plan shall use both behavioral health and positive behavior supports in a collaborative manner.~~"

(a) Comment: Shannon McCracken, Interim Executive Director, Kentucky Association of Private Providers; Brittany Knoth, Executive Director Path Forward of KY; Robert J. Illback, PsyD, ABPP, President and Chief Executive Officer of REACH of Louisville; Stephen S. Zaricki, MSW, Executive Director Community Living, Inc.; David Coons Family Home Provider; Meghen Wilson Growing Minds Learning Center; Jenifer C. Frommeyer, Executive Director Dreams With Wings; Leah F. Campbell, JD, Chief Operating Officer Apple Patch Community; Tomika H. Cosby, Executive Director Kentucky Case Management; Steve Frommeyer, Parent of a recipient of waiver services; Leigh Denniston of Almcare; Diane Quarles-Hartman, BS/MHA, Executive Director, Evergreen Life Services; Pamela J. Millay, R.N., J.D, Clinical Director/CPO Redwood; Myra Gribbins, Owner/Executive Director Reach for the stars Case Management; and Brad Schneider Vice President, Developmental Services Division LifeSkills, Inc. stated the following:

"In the previous waiver, it was only required that the Positive Behavior Support Specialist had one year experience working with individuals with intellectual or developmental disabilities. The two years requirement of direct service experience with individuals with the intellectual or developmental disabilities seems to be more cumbers than anything else. This would include Mental Health/Counselors, Licensed Psychologist, Licensed Dietitians, and Positive Behavior Support Specialist under the Consultative Clinical Therapies.

(b) Response: The qualifications for a positive behavior support specialist have not been revised in this regulation.

(a) Comment: Shannon McCracken, Interim Executive Director, Kentucky Association of Private Providers; Brittany Knoth, Executive Director Path Forward of KY; Robert J. Illback, PsyD, ABPP, President and Chief Executive Officer of REACH of Louisville; Stephen S. Zaricki, MSW, Executive Director Community Living, Inc.; David Coons Family Home Provider; Meghen Wilson Growing Minds Learning Center; Jenifer C. Frommeyer, Executive Director Dreams With Wings; Leah F. Campbell, JD, Chief Operating Officer Apple Patch Community; Tomika H. Cosby, Executive Director Kentucky Case Management; Steve Frommeyer, Parent of a recipient of waiver services; Leigh Denniston of Almcare; Diane Quarles-Hartman, BS/MHA, Executive Director, Evergreen Life Services; Pamela J. Millay, R.N., J.D, Clinical Director/CPO Redwood; Myra Gribbins, Owner/Executive Director Reach for the stars Case Management; and Brad Schneider Vice President, Developmental Services Division LifeSkills, Inc. stated the following:

“For the Positive Behavior Support Specialist, they must have at a Master’s Degree in behavioral science and one (1) years of experience in behavioral programming in addition to one (1) years of direct experience with individuals with intellectual or developmental disabilities. This seems to contradict the requirements set forth for professionals under Consultative Clinical Therapies on page 46, which also includes the Positive Behavior Support Specialist. What constitutes as “direct” experience? What is the state approved training that is mandatory? Will a Licensed professional have to complete these mandatory trainings if they are already covered under their licensure? Is this toward CEUs (page 83)? If their Licensure already has them doing CEUs, why are we asking these licensed professionals to duplicate potential CEU’s?”

(b) Response: The requirements for consultative clinical and therapeutic services does not contradict the requirements of a positive behavior support specialist but merely includes the PBSS as one of the professionals that can provide the service as long as they meet the personnel and training requirements established in Section 3 of this administrative regulation.

(a) Comment: Shannon McCracken, Interim Executive Director, Kentucky Association of Private Providers; Brittany Knoth, Executive Director Path Forward of KY; Robert J. Illback, PsyD, ABPP, President and Chief Executive Officer of REACH of Louisville; Stephen S. Zaricki, MSW, Executive Director Community Living, Inc.; David Coons Family Home Provider; Meghen Wilson Growing Minds Learning Center; Jenifer C. Frommeyer, Executive Director Dreams With Wings; Leah F. Campbell, JD, Chief Operating Officer Apple Patch Community; Tomika H. Cosby, Executive Director Kentucky Case Management; Steve Frommeyer, Parent of a recipient of waiver services; Leigh Denniston of Almcare; Diane Quarles-Hartman, BS/MHA, Executive Director, Evergreen Life Services; Pamela J. Millay, R.N., J.D, Clinical Director/CPO Redwood; Myra Gribbins, Owner/Executive Director Reach for the stars Case Management; and Brad Schneider Vice President, Developmental Services Division LifeSkills, Inc. stated the following:

“Finding someone that meets all the requirements is extremely challenging. Would like to see the 1---year of experience in behavior programming are eliminated or state either 1 year of behavior programing or 1 year of IDD.”

(b) Response: Thank you for your comment. The requirements for a positive behavior specialist were not revised in this regulation.

(a) Comment: Christopher D. George, M.Ed., BCBA, LBA owner and Executive Director of Applied Behavioral Advancements

“One of the other things contained in this regulation -- and, certainly, going through with the Division or with the inception of both counseling and positive behavior support being written into one thing, they’re not very clearly delineated. If you read the language under CCT, almost every single reference here in the lines that are there -- and, again, thank you for the good behavior and analytic language. But to my folks who are psychologists

or who may be providing individual counseling for someone, it is not within their purview of practice and, so, therefore, outside their disciplinary regulatory and ethical requirements for the services that they provide. Therefore, we have a regulation that is mandating the way that a specific discipline -- a licensed discipline goes through and operates within that to provide services to clients. This must change."

Christopher D. George, M.Ed., BCBA, LBA owner and Executive Director of Applied Behavioral Advancements, also stated the following:

"Certainly, as I look as a Behavior Analyst at the next section there, in looking at the behavioral health condition shall be considered the primary support service with behavioral interventions and supplemental services as needed. This regulation dictates that as a licensed Behavior Analyst that I must incorporate strategies and concepts that are from a different discipline. While I have worked in ICF/MRs, I have consulted with ICF/MRs -- I guess that would be ICF/DD currently -- and I'm currently on a contract with Central State Psychiatric Hospital providing services to those diagnosed with just mental illness, I'm very familiar with the inter-disciplinary roles of both a counselor as well as a psychologist in order to meet the needs of those with mental illness. And I have been able to have some very successful teams where we work together as far as the treatment plan that came down. However, my behavior analytic behavior support plan was separate from their clinical mental health treatment plan. And they should remain as such because our disciplines dictate so - in collaboration. So, I would recommend that the Cabinet go back and look at the wording here to allow for clinical discretion and recommendations within this. I would recommend that the Cabinet go back and look at the overall combination. Now is a really good time to separate these out. We tried it. We tried it. We did our best. I know as an agency we did our best. And we have worked within the guidelines for the last several years, but it's time to change them and allow us to operate independently as clinicians; part of a collaborative team but not lumped together as one. Because the role of a psychologist or a counselor is to work one-on-one with that individual to help remediate the symptoms of their diagnosed mental illness. That can be through counseling. There are a number of different ways. I'm not going to speak for those psychologists."

(b) Response: Thank you for your comments. At this time, the regulation does not address specific disciplines or mandate specific practitioner licenses for positive behavior supports. It requires the services to be provided by a "positive behavior support specialist" which it defines as follows:

"(80)[~~(73)~~] 'Positive behavior support specialist' means an individual who;
(a) Provides evidence-based individualized interventions that assist a participant with acquisition or maintenance of skills for community living and behavioral intervention for the reduction of maladaptive behaviors;
(b) Has a master's degree in a behavioral science and one (1) year of experience in behavioral programming;
(c) Has at least one (1) year of direct service experience with individuals with intellectual or developmental disabilities;

(d) Meets all personnel and training requirements established in Section 3 of this administrative regulation; and
(e) Participates in at least six (6) hours per year of professional development or continuing education in the areas of psychology, behavioral supports, applied behavioral science, or school psychology."

(27) Subject: Billing Person Centered Team Meetings

(a) Comment: Therapeutic Intervention Services, PLLC, made the following comment:

"Section 1.76.c.3 Minus the annual Person Centered Service Plan meeting, it should be acceptable for persons to bill during Person Centered Team meetings. Without allowing the impact services, consultative clinical therapies, and other services whose purpose is as a support on a team, these vital team members may choose to not be physically present for the team meetings as they will not be reimbursed for their services. If there is a mechanism for which they could get reimbursed for team meetings, which would add to the qualitv of the teams."

(b) Response: There is no payment mechanism for any provider to attend a team meeting. This is considered part of the cost of doing business.

(28) Subject: Identifying Strategies for Managing Consequences to Maximize Reinforcement of Adaptive or Positive Behavior

(a) Comment: Therapeutic Intervention Services, PLLC, made the following comment:

"Section 4.14 e This line in the proposed regulation is not necessary."

(b) Response: We could not find a Section 4.14.e and are uncertain to what the reference is being made.

(29) Subject: Family Home Providers

(a) Comment: Therapeutic Intervention Services, PLLC, made the following comment:

"Request for pre-existing relationships of Family Home Providers who are guardians, be allowed to continue with the understanding that no new conflictual relationships may occur with an SCL provider."

(b) Response: New admissions into the waiver are not able to enter into a residential level II service in which the guardian is the provider of the service.

(30) Subject: Date of Regulation Changes

(a) Comment: Therapeutic Intervention Services, PLLC, made the following comment:

“When will individuals in the SCL waiver change over to the new regulations? Since there is a new Person Centered Service Plan document (MAP 116), when will individuals whose services are still documented under the MAP 530 be transitioned to this new document? How will the transition occur: prior to the LOC end year date or upon the next approval of services?”

(b) Response: The transition to new requirements including conflict free case management will occur at the participant’s next level of care certification following implementation of the regulation. The regulation is currently on track to become effective in February 2016. Thus, from that date forward when an individual is recertified to continue to receive services via the waiver the therapies will be shifted to being a state plan benefit for the individual rather than an SCL waiver benefit.

For example, an individual whose recertification occurs in March 2016 will not be able to receive therapies as a waiver benefit beginning March 2016 but will be able to receive them as a state plan benefit. An individuals whose next recertification does not occur until December 2016 will continue to be able to receive therapies as an SCL waiver benefit until December 2016. Following recertification in December 2016 therapy benefits for that individual would shift to being covered as a state plan benefit.

(31) Subject: Corrective Application Plan

(a) Comment: Tanya Dickinson, Department for Behavioral Health, Developmental & Intellectual Disabilities made the following comment:

“Comment:
Comment:
Upon a finding of non-compliance with policies described in Kentucky Administrative Regulations (KAR) regarding a 1915 (c) home or community based services waiver program, the regulation does not clearly specify an allowed period for provider response to a citation(s), provider creation and submission of a Corrective Action Plan(s) (CAP) to the department, provider revision and re-submission of a rejected CAP to the department, , or potential consequences if an acceptable CAP is not ultimately submitted.

Recommendation:
Due to the potential for serious life/safety issues, and increased adverse effects on vulnerable individuals, the provider shall comply with the following requirements for Corrective Action Plans (CAPs): When the provider receives a findings report from the department indicating that issues of non-compliance have been cited, the agency has: Ten (10) business days from the date of the cover letter to submit the CAP per instructions noted in the cover letter. If a provider is notified by the Department that CAP-1 was not approved, the provider shall submit a revised CAP within: Ten (10) business days from the date of the cover letter per instructions noted in the cover letter. If a provider is notified by the Department that CAP-2 was not approved, the Executive Director may request to meet with the Waiver Manager as soon as possible but must

submit a revised CAP within: Five (5) business days from the date of the cover letter per instructions noted in the cover letter.

Cited providers shall submit an initial CAP and up to two (2) department-directed revisions (for a total of three (3) submissions). The department's allowable period to review revisions submitted should be thirty (30) business days. (907 KAR 7:005 specifies that the department shall have "thirty (30) days" to review a CAP. This should be clarified to mean thirty (30) business days for consistency.)

Citations are not appealable. If the provider does not submit an acceptable CAP within these guidelines, the department shall recommend to DMS that: the agency not be certified as a new provider agency; the provider certification not be renewed; or the provider certification be terminated. Providers have the option to appeal termination."

(b) Response: DMS will file an "amended after comments" regulation with the Legislative Research Commission to insert the following provisions regarding corrective action plans:

Section 14. Corrective Action Plans. (1)(a) If a provider receives a findings report from the Division of Developmental and Intellectual Disabilities (DDID) indicating that an issue of non-compliance has been cited, the provider shall have ten (10) business days from the date on the letter that accompanied the findings report to submit a corrective action plan to DDID in accordance with the instructions in the letter.
(b) If a provider is notified by DDID that the corrective action plan was not approved, the provider shall submit a revised corrective action plan to DDID within ten (10) business days of the date on the letter informing that the initial corrective action plan was not approved and in accordance with the instructions in the letter.
(c)1. If a provider is notified by DDID that the second corrective action plan was not approved, the provider shall submit a revised corrective action plan to DDID within five (5) business days from the date on the letter notifying that the second corrective action plan was not approved.
2. If the third corrective action plan submitted to DDID is not approved, DDID shall recommend to the department that the:
a. Provider not be certified as a new provider if it is a new provider;
b. Provider not be recertified if the provider is an existing provider; or
c. Provider's certification be terminated.
3. A provider shall have the right to appeal a termination in accordance with 907 KAR 1:671.
(2) DDID shall have up to thirty (30) business days to review a corrective action plan.

(32) Subject: Certification

(a) Comment: Tanya Dickinson, Department for Behavioral Health, Developmental & Intellectual Disabilities made the following comment:

"*Comment:*

The regulation stipulates that providers shall be certified "at least" biennially by the department. Does this mean that providers may be certified or recertified more frequently as a result or consequence of a CAP, or for other causes?
Recommendation:

Yes. According to the schedule below, recertification lengths should be re-assessed at the scheduled recertification date and based on: citations identified during a recertification review; citations issued during the prior twenty-four (24) month period; submission of an approved CAP (or revision); successful implementation of an approved CAP (or revision); repeat citation(s); Health/Safety/Welfare Citations; and other significant issues identified by the department.

Provider Status (at Recertification Date)	**Certification Period**
• Zero (0) citations during the prior twenty-four (24) month period	Two (2) Years
• Zero (0) citations during the most recent recertification review • Successfully implemented the approved CAP for any citations issued during the recertification period.	One (1) Year
• Received citations during the most recent recertification review • Existing (open) citations without either an accepted CAP or a successfully implemented CAP	Six (6) Months • Upon approval of CAP, department will monitor for successful implementation within 30 days • Upon successful implementation of CAP, department may extend recertification to balance of one year • If provider fails to implement an approved CAP, department may extend timeframe for implementation or recommend non-renewal or termination to DMS If provider has not submitted an approved CAP after the three (3) allowed attempts (see above), department will recommend non-renewal or termination to DMS

(b) Response: DMS will file an "amended after comments" regulation with the

Legislative Research Commission to insert the following provisions regarding certification periods:

"Section 15. Provider Certification. The following shall apply regarding SCL provider certification periods:

Provider Status at Recertification Date	New Certification Period Based on Status at Recertification Date
Zero (0) citations during the prior twenty-four (24) month period	Two (2) Years
Zero (0) citations during the most recent recertification review and have successfully implemented any approved corrective action plan for any citation issued during the recertification period if any citation was issued	One (1) year
Received citations during the most recent recertification review or has existing (open) citations without either an accepted corrective action plan or a successfully implemented corrective action plan	Six (6) Months (1) Upon approval of corrective action plan, the department shall monitor for successful implementation within thirty (30) days. (2) Upon successful implementation of corrective action plan, the department shall extend recertification to balance of one (1) year. (3) If provider fails to implement an approved corrective action plan, the Division of Developmental and Intellectual Disabilities (DDID) shall extend the timeframe for implementation or recommend non-renewal or termination to the department. (4) If provider has not submitted an approved corrective action plan after the three (3) allowed attempts (see above), the department will recommend non-renewal or termination to the department.

(a) Comment: Jodi Wilson, Regional Director of ResCare, made the following comment:

"I also have numerous HUGE concerns about the proposed certification process

changes."

(b) Response: Thank you for your comment. Please refer to the response above regarding changes to this process. Due to health, safety, and welfare concerns of participants, DMS will file an "amended after comments" administrative regulation with the Legislative Research Commission to allow for shorter certification timeframes for providers who are cited for various violations. A core requirement of 1915(c) home and community based waiver programs – as mandated by CMS and with which DMS wholly endorses – is to protect the health, safety, and welfare of program participants. The certification changes will help enhance participant health, safety, and welfare.

(33) Subject: Voluntary Moratorium

(a) Comment: Tanya Dickinson, Department for Behavioral Health, Developmental & Intellectual Disabilities made the following comment:

"Comment:
907 KAR 7:005, Certified waiver provider requirements, requires that the department offer a provider a "voluntary moratorium" while it conducts an investigation as an alternative to immediate termination of provider certification in the event reliable evidence leads the department to believe that a certified provider has committed a violation that threatens the health, safety or welfare of a recipient. The voluntary moratorium will remain in effect through the CAP development, review/approval process, and implementation. However, there is no specified process in this regulation for: formally ascertaining a provider's acceptance of the voluntary moratorium; the specific circumstances of its imposition (e.g., start date, alternatives/consequences); or the department's actions if termination should occur.

Recommendation:
Upon notice of the potential health, safety or welfare violation, the Department shall contact the provider's Executive Director to officially notify the agency of the option for Voluntary Moratorium and to discuss the health, safety, or welfare concern(s). The department's notice to the provider shall be by phone followed by electronic means. Upon receipt of electronic notice, the provider shall either formally accept (agree) or not accept (not agree) the option for Voluntary Moratorium by signing the provided document, and returning it to the department within two (2) business days of receipt via electronic means as directed in the electronic notice.

If Voluntary Moratorium is accepted by the provider, the department will continue proceedings as required by 907 KAR 7:005. If Voluntary Moratorium is NOT accepted by the provider, the department will work in conjunction with DMS to continue proceedings as required by 907 KAR 7:005, and notify the provider's Executive Director at the agency's primary business address, in writing, of the reason for termination and the provider's right to appeal the termination within two (2) business days of receipt of the written non-acceptance of the option for Voluntary Moratorium, or within five (5) business days of the initial notice sent to the provider, if the provider does not respond

to the notice of the option for Voluntary Moratorium. The notice of termination to the provider will be sent via delivery service that records both sending and receipt (e.g., certified mail, overnight delivery service).

In the event of termination, the department's role is one of monitoring the agency's efforts to ensure the health, safety and welfare of individuals and providing technical assistance during the transition process. The provider is required to fully cooperate with the department's transition team and other state agencies, and must provide full access to agency records and information about the individuals supported. The provider is responsible for facilitating the effective transition of individuals to the agencies of their choice prior to the termination date. The termination date is noted in the letter and funding is no longer available after that point. Case managers also have a role in ensuring the transition process is complete prior to the date of termination. APS could be notified of potential caretaker neglect if the agency under termination is not cooperating."

(b) Response: DMS will file an "amended after comments" regulation with the Legislative Research Commission to insert the following provisions regarding voluntary moratoriums:

"Section 16. Voluntary Moratorium. (1)(a) Upon the department becoming aware of a potential health, safety, or welfare violation, the department shall contact the provider's executive director to:
1. Officially notify the provider of the option for a voluntary moratorium; and
2. Discuss the health, safety, or welfare concern.
(b) The department's notice to the provider shall initially be made via phone followed up by notice via electronic means.
(c) Upon receipt of the electronic notice, the provider shall formally accept or not accept the voluntary moratorium option by:
1. Signing the document provided; and
2. Returning it to the department within two (2) business days of receipt by electronic means as directed in the electronic notice.
(2) If the provider:
(a) Agrees to a voluntary moratorium, the department shall proceed as established in 907 KAR 7:005 regarding a voluntary moratorium pending an investigation; or
(b) Does not agree to a voluntary moratorium, the department shall:
1. Terminate the provider in accordance with 907 KAR 7:005; and
2. Notify in writing the provider's executive director at the agency's primary business address of the:
a. Reason for termination; and
b. Provider's right to appeal the termination within:
(i) Two (2) business days of receipt of the written non-acceptance of the voluntary moratorium; or
(ii) Five (5) business days of the initial notice sent to the provider if the provider did not respond to the notice of the voluntary moratorium option.

(3) A notice of termination to the provider shall be sent via a delivery method that records the sending and receipt of the notice.
(4)(a) If a provider is terminated, the department shall:
1. Monitor the provider's efforts to ensure the health, safety, and welfare of participants in need of being transitioned to a new provider; and
2. Provide technical assistance to the provider during the transition.
(b) A provider shall:
1. Fully cooperate with the department's transition assistance team and any other state government agency involved;
2. Provide full access to its records and information pertaining to the participants being transitioned; and
(c) Be responsible for facilitating the effective transition of participants to another provider or providers of the participant's choice prior to the termination date.
(d) A provider's termination date shall be stated in the termination notice.
(e) A participant's case manager shall help ensure that the participant's transition to a new provider or providers is completed prior to the termination date."

(34) Subject: Quality Improvement Plan

(a) Comment: Steven Shannon, Executive Director, Kentucky Association of Regional Programs, Inc. made the following comment:

"We fully support the inclusion of a quality improvement plan (Section 3 (3) 5. b. (ii) – (v)) and commend the Cabinet for emphasizing quality improvement. We would like to have the opportunity to discuss how some components included in the quality improvement plan will be measured. For example, how will item (ii), listed below, which includes respected in the community be measured?

5. A quality improvement plan that:
a. Includes updated findings and corrective actions as a result of department and case management quality assurance monitoring; and
b. Addresses how the provider shall accomplish the following goals:
(i) Ensure that the participant receives person-centered SCL waiver services;
(ii) Enable the participant to be safe, healthy, and respected in the participant's community;
(iii) Enable the participant to live in the community with effective, individualized assistance;
(iv) Enable the participant to enjoy living and working in the participant's community; and
(v) Improve the participant's competence;"

(b) Response: The person centered team works together to ensure that the person is safe and healthy and is treated respectfully. This is a collaborative effort by the team to encourage and support a positive and meaningful life for the person. Frequent communication between team members is important in order to measure a person's satisfaction with their lives, which is directly impacted by how safe, healthy and

respected a person communicates they are.

DMS will file an “amended after comments” administrative regulation with the Legislative Research Commission to remove the following from the regulation:

“(v) Improve the participant’s competence.”

(35) Subject: Participant Directed Services

(a) Comment: Steven Shannon, Executive Director, Kentucky Association of Regional Programs, Inc. made the following comment:

“Section 10 delineates the requirements for participant directed services (PDS). It is recommended that section 10. (7) (c) be clarified by adding the financial management agency shall “Process employer-related payroll and deposit and as directed by the participant withhold necessary mandatory employer withholdings;”

This amended language will clarify that the withholding decision is made by the participant or their representative as the employer and the financial management agency is acting at their direction.”

(b) Response: Thank you for your comment. DMS needs additional time to consider this and will consider the recommendation for future waiver amendments.

(a) Comment: Jean M Russell, Vice President, Developmental Services, Seven Counties Services, stated the following:

“Secondarily, I would also say again, in my opinion and in Seven Counties’ opinion, if a consumer is selecting person-directed supports, they get to select person-directed supports for anything and everything they want. They’re in control. That means they should be able to select who provides those services, whether it’s done through an employee or an agency and regardless if that agency is also providing the support broker role.”

(b) Response: The conflict-free provider requirement is federally mandated by the agency which provides federal funds for the SCL waiver program (Centers for Medicare and Medicaid Services) and is not an optional requirement.

(36) Subject: Inconsistent Application of Regulation

(a) Comment: Jodi Wilson, Regional Director of ResCare, made the following comment:

“The inconsistent application of regulation across the Commonwealth - some agencies receiving citation and some ‘technical assistance’ with no clear-cut guidance to everyone in order that we might all operate off the same page.”

(b) Response: Thank you for your comment. DMS would welcome specific examples.

(37) Subject: Person Centered Coach

(a) Comment: Shannon McCracken, Interim Executive Director, Kentucky Association of Private Providers; Brittany Knoth, Executive Director Path Forward of KY; Robert J. Illback, PsyD, ABPP, President and Chief Executive Officer of REACH of Louisville; Stephen S. Zaricki, MSW, Executive Director Community Living, Inc.; David Coons Family Home Provider; Meghen Wilson Growing Minds Learning Center; Jenifer C. Frommeyer, Executive Director Dreams With Wings; Leah F. Campbell, JD, Chief Operating Officer Apple Patch Community; Tomika H. Cosby, Executive Director Kentucky Case Management; Steve Frommeyer, Parent of a recipient of waiver services; Leigh Denniston of Almcare; Diane Quarles-Hartman, BS/MHA, Executive Director, Evergreen Life Services; Pamela J. Millay, R.N., J.D, Clinical Director/CPO Redwood; Myra Gribbins, Owner/Executive Director Reach for the stars Case Management; and Brad Schneider Vice President, Developmental Services Division LifeSkills, Inc. stated the following:

"In the previous waiver, the Person Centered Coach was to work under the direction of a Positive Behavior Support Specialist or other Licensed Professional in the setting where the POC is implemented. Now, they are to be only under the supervision of a Positive Behavior Specialist, but yet they are still functioning to monitor, train, and assess effectiveness of person centered planning. The Person Centered Plan may not just be the work other Positive Behavior Specialist, but could also entail the efforts of a Mental Health/Counselor (such as an LCSW), Licensed Psychologist, and/or Dietitian. Are they responsible for the modeling, monitoring, assessing, and implementing the Person Centered Plan or the Positive Behavior Support Plan? These are two different documents with two distinctive functions in the waiver. If a Positive Behavior Specialist is not on the Person Centered Plan, is the Person Centered Coach still expected to be supervised by the Positive Behavior Support Specialist?"

(b) Response: The requirement for a person centered coach is as follows:

"(a) Person-centered coaching shall:
1. Be provided by a person-centered coach who shall:
a. Operate independently of a residential or day training provider;
b. Work under the direction of a positive behavior support specialist or other licensed professional in the settings where the person-centered service plan is implemented; and
c. Meet the personnel and training requirements specified in Section 3 of this administrative regulation."

(38) Subject: Removal of Daily Notes

(a) Comment: Shannon McCracken, Interim Executive Director, Kentucky Association of Private Providers; Brittany Knoth, Executive Director Path Forward of KY; Robert J. Illback, PsyD, ABPP, President and Chief Executive Officer of REACH of

Louisville; Stephen S. Zaricki, MSW, Executive Director Community Living, Inc.; David Coons Family Home Provider; Meghen Wilson Growing Minds Learning Center; Jenifer C. Frommeyer, Executive Director Dreams With Wings; Leah F. Campbell, JD, Chief Operating Officer Apple Patch Community; Tomika H. Cosby, Executive Director Kentucky Case Management; Steve Frommeyer, Parent of a recipient of waiver services; Leigh Denniston of Almcare; Diane Quarles-Hartman, BS/MHA, Executive Director, Evergreen Life Services; Pamela J. Millay, R.N., J.D, Clinical Director/CPO Redwood; Myra Gribbins, Owner/Executive Director Reach for the stars Case Management; and Brad Schneider Vice President, Developmental Services Division LifeSkills, Inc. stated the following:

“KAPP has also requested since 2013 that the requirement for Daily Notes be removed. This was an administrative burden that didn’t exist prior to this waiver implementation.”

(b) Response: Daily notes are needed to ensure that services are provided as required and are necessary as services are subject to audit by several entities including the Centers for Medicare and Medicaid Services (as well as subject to recoupment by CMS).

(39) Subject: Focus Tool

(a) Comment: Shannon McCracken, Interim Executive Director, Kentucky Association of Private Providers; Brittany Knoth, Executive Director Path Forward of KY; Robert J. Illback, PsyD, ABPP, President and Chief Executive Officer of REACH of Louisville; Stephen S. Zaricki, MSW, Executive Director Community Living, Inc.; David Coons Family Home Provider; Meghen Wilson Growing Minds Learning Center; Jenifer C. Frommeyer, Executive Director Dreams With Wings; Leah F. Campbell, JD, Chief Operating Officer Apple Patch Community; Tomika H. Cosby, Executive Director Kentucky Case Management; Steve Frommeyer, Parent of a recipient of waiver services; Leigh Denniston of Almcare; Diane Quarles-Hartman, BS/MHA, Executive Director, Evergreen Life Services; Pamela J. Millay, R.N., J.D, Clinical Director/CPO Redwood; Myra Gribbins, Owner/Executive Director Reach for the stars Case Management; and Brad Schneider Vice President, Developmental Services Division LifeSkills, Inc. stated the following:

“KAPP also commented on the Focus Tool as the only DBHDID approved monitoring tool: The invent of the KY Focus Tool has been extremely difficult to initiate and acts to create an adversarial approach between case management agencies and service providers by asking for ongoing ratings and correction plans. The tool itself does not capture all necessary information and no clear direction has been given for its use or intentions. Prior to the Focus Tool, case managers were able to use agency driven forms that captured far more information and were much more proficient in documenting a recipient’s ongoing progress. One point of concern with the Focus Tool is the requirement to ask a recipient the same questions every month, including ones about employment, whether they have interest or not. It is KAPP’s position the Focus Tool requirement be removed and autonomy within documentation be given back to case

management providers."

Shannon McCracken, Interim Executive Director, Kentucky Association of Private Providers; Brittany Knoth, Executive Director Path Forward of KY;
Robert J. Illback, PsyD, ABPP, President and Chief Executive Officer of REACH of Louisville; Stephen S. Zaricki, MSW, Executive Director Community Living, Inc.;
David Coons Family Home Provider; Meghen Wilson Growing Minds Learning Center;
Jenifer C. Frommeyer, Executive Director Dreams With Wings; Leah F. Campbell, JD, Chief Operating Officer Apple Patch Community; Tomika H. Cosby, Executive Director Kentucky Case Management; Steve Frommeyer, Parent of a recipient of waiver services; Leigh Denniston of Almcare; Diane Quarles-Hartman, BS/MHA, Executive Director, Evergreen Life Services; Pamela J. Millay, R.N., J.D, Clinical Director/CPO Redwood; Myra Gribbins, Owner/Executive Director Reach for the stars Case Management; and Brad Schneider Vice President, Developmental Services Division LifeSkills, Inc. stated the following:

"The reference for case managers to utilize a DBHDID approved monitoring tool, should allow the Kentucky Focus Tool to be optional. After 2 years, case managers have found it to be repetitive, burdensome and not at all person centered. Participants report being tired of answering the same questions every month. Guardianship, when renegotiating the MOU with Case Managers requested that they NOT send them, as they are repetitive from the basic face---to---face documentation emails they receive. We request that the Kentucky Focus Tool be one option for an approved monitoring tool."

Shannon McCracken, Interim Executive Director, Kentucky Association of Private Providers; Brittany Knoth, Executive Director Path Forward of KY;
Robert J. Illback, PsyD, ABPP, President and Chief Executive Officer of REACH of Louisville; Stephen S. Zaricki, MSW, Executive Director Community Living, Inc.;
David Coons Family Home Provider; Meghen Wilson Growing Minds Learning Center;
Jenifer C. Frommeyer, Executive Director Dreams With Wings; Leah F. Campbell, JD, Chief Operating Officer Apple Patch Community; Tomika H. Cosby, Executive Director Kentucky Case Management; Steve Frommeyer, Parent of a recipient of waiver services; Leigh Denniston of Almcare; Diane Quarles-Hartman, BS/MHA, Executive Director, Evergreen Life Services; Pamela J. Millay, R.N., J.D, Clinical Director/CPO Redwood; Myra Gribbins, Owner/Executive Director Reach for the stars Case Management; and Brad Schneider Vice President, Developmental Services Division LifeSkills, Inc. stated the following:

"With the transition into MWMA underway, Case Managers are required to upload the "contact note" and the "monthly summary" for each participant each month. Because the Kentucky Focus Tool is the only approved DBHDID monitoring tool currently, case managers have to either a) upload the large multi---page Focus Tool twice per month per person (which takes a very long time) or b) utilize apps that will break apart the document, convert it to pdf, etc. That is after typing the notes into a Word document, copying and pasting it into the Focus Tool.

KAPP understands the intent of the Focus Tool was good, but it has involved into something that is technically difficult, incompatible with some agency's software systems (Mac) and too time consuming due to the MWMA system.

KAPP requests that the KFT becomes optional and that case managers be allowed to do a contact note and monthly summary as all other waivers do. We should not be held to a higher standard. No other waiver service has a standardized documentation tool."

(b) Response: Thank you for your comments. DMS will file an "amended after comments" administrative regulation with the Legislative Research Commission to delete the DBHDID monitoring tool as requested and simply have the case manager utilize the MWMA portal. The revision will be as follows:

"3. A case manager shall utilize MWMA to [~~a DBHDID-approved monitoring tool~~] to".

(40) Subject: Health Risk Screening Tool

(a) Comment: Shannon McCracken, Interim Executive Director, Kentucky Association of Private Providers; Brittany Knoth, Executive Director Path Forward of KY; Robert J. Illback, PsyD, ABPP, President and Chief Executive Officer of REACH of Louisville; Stephen S. Zaricki, MSW, Executive Director Community Living, Inc.; David Coons Family Home Provider; Meghen Wilson Growing Minds Learning Center; Jenifer C. Frommeyer, Executive Director Dreams With Wings; Leah F. Campbell, JD, Chief Operating Officer Apple Patch Community; Tomika H. Cosby, Executive Director Kentucky Case Management; Steve Frommeyer, Parent of a recipient of waiver services; Leigh Denniston of Almcare; Diane Quarles-Hartman, BS/MHA, Executive Director, Evergreen Life Services; Pamela J. Millay, R.N., J.D, Clinical Director/CPO Redwood; Myra Gribbins, Owner/Executive Director Reach for the stars Case Management; and Brad Schneider Vice President, Developmental Services Division LifeSkills, Inc. stated the following:

"KAPP's Comments in 2013: While recognizing the HRST as a helpful tool in providing quality supports, this has increased cost and administrative burden to primary providers, by requiring an RN to complete these assessments. The agency must either hire or contract with a Registered Nurse to perform this service, with no mechanism for reimbursement. Furthermore, it has been mandated HRST's must be updated within 3 days of a change which is impractical as well as unfunded and creates tremendous administrative burden on a provider agency.

KAPP's 2 year long recommendation has been: the requirement to update within 3 days is an unnecessary administrative burden, except for MAJOR changes in health or diagnosis. Change the requirement to "every medication change" and "change in the way a person feels" to monthly."

(b) Response: Thank you for the suggestions. The cabinet is not comfortable adopting the recommendation at this time but will continue to monitor and review this.

(a) Comment: Shannon McCracken, Interim Executive Director, Kentucky Association of Private Providers; Brittany Knoth, Executive Director Path Forward of KY; Robert J. Illback, PsyD, ABPP, President and Chief Executive Officer of REACH of Louisville; Stephen S. Zaricki, MSW, Executive Director Community Living, Inc.; David Coons Family Home Provider; Meghen Wilson Growing Minds Learning Center; Jenifer C. Frommeyer, Executive Director Dreams With Wings; Leah F. Campbell, JD, Chief Operating Officer Apple Patch Community; Tomika H. Cosby, Executive Director Kentucky Case Management; Steve Frommeyer, Parent of a recipient of waiver services; Leigh Denniston of Almcare; Diane Quarles-Hartman, BS/MHA, Executive Director, Evergreen Life Services; Pamela J. Millay, R.N., J.D, Clinical Director/CPO Redwood; Myra Gribbins, Owner/Executive Director Reach for the stars Case Management; and Brad Schneider Vice President, Developmental Services Division LifeSkills, Inc. stated the following:

"We are optimistic about some proposed changes to the protocol, which would allow residential staff that go through the HRST Training process to conduct initial HRST's and updates. However, the protocol STILL requires an RN employed by or contracted with the provider to do monitoring and follow---ups per HRST ratings."

(b) Response: In 2012, the residential rates were increased by $4.00 per person per day to support registered nurse activities associated with health screening and medication administration training by the agencies. This equates to almost $6 million in reimbursement to provider agencies per year.

Evidence supports that there exists a significant cost factor for detected and/or undetected health issues. Significant time can be focused on behavioral issues that may well have their root cause in medical issues and drug interactions. The goal here is to find better strategies and solutions to help people in health management. Research has clearly demonstrated that as health improves, support needs and overall cost of care decreases.

(a) Comment: Shannon McCracken, Interim Executive Director, Kentucky Association of Private Providers; Brittany Knoth, Executive Director Path Forward of KY; Robert J. Illback, PsyD, ABPP, President and Chief Executive Officer of REACH of Louisville; Stephen S. Zaricki, MSW, Executive Director Community Living, Inc.; David Coons Family Home Provider; Meghen Wilson Growing Minds Learning Center; Jenifer C. Frommeyer, Executive Director Dreams With Wings; Leah F. Campbell, JD, Chief Operating Officer Apple Patch Community; Tomika H. Cosby, Executive Director Kentucky Case Management; Steve Frommeyer, Parent of a recipient of waiver services; Leigh Denniston of Almcare; Diane Quarles-Hartman, BS/MHA, Executive Director, Evergreen Life Services; Pamela J. Millay, R.N., J.D, Clinical Director/CPO Redwood; Myra Gribbins, Owner/Executive Director Reach for the stars Case Management; and Brad Schneider Vice President, Developmental Services Division LifeSkills, Inc. stated the following:

“KAPP would also ask the division to re-evaluate the agency’s practical use of the HRST as an effective tool.”

(b) Response: Thank you for your recommendation and the cabinet will indeed re-evaluate the tool as requested. Doing so fits with our desire to focus on continued quality improvement.

(a) Comment: Lisa A. (Chaplin) Wise, BS Special Edu, Assistant Director Communicare made the following comment:

“Section 3: Non-PDS Provider Participation Requirements; Has the HRST been removed from the regulation requirement?”

(b) Response: The regulation requires a department approved screening tool to assess health risk. At this time, the HRST is a department-approved tool.

(41) Subject: Medication Administration and the Provision of Other Medical Support Services

(a) Comment: Shannon McCracken, Interim Executive Director, Kentucky Association of Private Providers; Brittany Knoth, Executive Director Path Forward of KY; Robert J. Illback, PsyD, ABPP, President and Chief Executive Officer of REACH of Louisville; Stephen S. Zaricki, MSW, Executive Director Community Living, Inc.; David Coons Family Home Provider; Meghen Wilson Growing Minds Learning Center; Jenifer C. Frommeyer, Executive Director Dreams With Wings; Leah F. Campbell, JD, Chief Operating Officer Apple Patch Community; Tomika H. Cosby, Executive Director Kentucky Case Management; Steve Frommeyer, Parent of a recipient of waiver services; Leigh Denniston of Almcare; Diane Quarles-Hartman, BS/MHA, Executive Director, Evergreen Life Services; Pamela J. Millay, R.N., J.D, Clinical Director/CPO Redwood; Myra Gribbins, Owner/Executive Director Reach for the stars Case Management; and Brad Schneider Vice President, Developmental Services Division LifeSkills, Inc. stated the following:

“The regulations related to medication administration and the provision of other medical support services is an unfunded mandate because no additional funding is provided to support the hiring of nurses or contracting with nurses under the current rate structure. Increasingly, agencies are being held to traditional medical model standards of practice and as a result, nursing staff is secured at great expense to the provider without any or sufficient reimbursement. The health and wellness of all service participants is of paramount importance, but this service should be funded if it is demanded by regulation.”

(b) Response: In 2012, the residential rates were increased by $4.00 per person per day to support registered nurse activities associated with health screening and medication administration training by the agencies. This equates to almost $6 million in reimbursement to provider agencies per year. Evidence supports that there exists a

significant cost factor for detected and/or undetected health issues. Significant time can be focused on behavioral issues that may well have their root cause in medical issues and drug interactions. The goal here is to find better strategies and solutions to help people in health management. Research has clearly demonstrated that as health improves, support needs and overall cost of care decreases.

(42) Subject: Documentation Requirements

(a) Comment: Shannon McCracken, Interim Executive Director, Kentucky Association of Private Providers; Brittany Knoth, Executive Director Path Forward of KY; Robert J. Illback, PsyD, ABPP, President and Chief Executive Officer of REACH of Louisville; Stephen S. Zaricki, MSW, Executive Director Community Living, Inc.; David Coons Family Home Provider; Meghen Wilson Growing Minds Learning Center; Jenifer C. Frommeyer, Executive Director Dreams With Wings; Leah F. Campbell, JD, Chief Operating Officer Apple Patch Community; Tomika H. Cosby, Executive Director Kentucky Case Management; Steve Frommeyer, Parent of a recipient of waiver services; Leigh Denniston of Almcare; Diane Quarles-Hartman, BS/MHA, Executive Director, Evergreen Life Services; Pamela J. Millay, R.N., J.D, Clinical Director/CPO Redwood; Myra Gribbins, Owner/Executive Director Reach for the stars Case Management; and Brad Schneider Vice President, Developmental Services Division LifeSkills, Inc. stated the following:

"With the implementation of this regulation, along came a briar patch of additional paperwork in the form of daily notes and monthly summaries for the most frequently provided services. The exacting and tedious nature of this documentation combined with the stringent standards used by state monitors has resulted in MILLIONS of dollars of earned income that has been returned to the department for such minor and insubstantial errors as notes that simply lack signature, titles or dates. We urge the Department to simplify its overly burdensome documentation requirements and to provide increased technical assistance to avoid recoupments for minor errors."

(b) Response: Thank you for your comments. The Department will continue to provide technical assistance to providers in providing quality services and documentation of such.

(43) Subject: Cost of Administrative Requirements on Providers

(a) Comment: Shannon McCracken, Interim Executive Director, Kentucky Association of Private Providers; Brittany Knoth, Executive Director Path Forward of KY; Robert J. Illback, PsyD, ABPP, President and Chief Executive Officer of REACH of Louisville; Stephen S. Zaricki, MSW, Executive Director Community Living, Inc.; David Coons Family Home Provider; Meghen Wilson Growing Minds Learning Center; Jenifer C. Frommeyer, Executive Director Dreams With Wings; Leah F. Campbell, JD, Chief Operating Officer Apple Patch Community; Tomika H. Cosby, Executive Director Kentucky Case Management; Steve Frommeyer, Parent of a recipient of waiver services; Leigh Denniston of Almcare; Diane Quarles-Hartman, BS/MHA, Executive

Director, Evergreen Life Services; Pamela J. Millay, R.N., J.D, Clinical Director/CPO Redwood; Myra Gribbins, Owner/Executive Director Reach for the stars Case Management; and Brad Schneider Vice President, Developmental Services Division LifeSkills, Inc. stated the following:

“Providers are dealing with increased administrative requirements that have hefty price tags, increased costs of utilities, food, property and liability insurance and staff costs such as pay increases, health insurance, and the increased costs of life in general. There must be discussion about the current rates especially in light of the increased scrutiny and requirements that are coming with the CMS Final Rule.”

“We must have increased rates; we cannot keep absorbing costs.”

(b) Response: Thank you for your comments. No rate changes are being considered at this time.

(44) Subject: Transportation to Visit Service Sites

(a) Comment: Lisa A. (Chaplin) Wise, BS Special Edu, Assistant Director Communicare made the following comment:

“Section 2: SCL Participant Eligibility, Enrollment, and Termination; Who will pay or reimburse for the transportation to visit service sites? Currently a PA (to the location) is required for transportation to be reimbursed.”

(b) Response: Transportation is a component of several services including residential and day training. If a provider terminates services to a participant, it is that provider’s responsibility to “arrange and provide transportation for a requested visit to an SCL provider site.”

(45) Subject: Nurse Contracting

(a) Comment: Shannon McCracken, Interim Executive Director, Kentucky Association of Private Providers; Brittany Knoth, Executive Director Path Forward of KY; Robert J. Illback, PsyD, ABPP, President and Chief Executive Officer of REACH of Louisville; Stephen S. Zaricki, MSW, Executive Director Community Living, Inc.; David Coons Family Home Provider; Meghen Wilson Growing Minds Learning Center; Jenifer C. Frommeyer, Executive Director Dreams With Wings; Leah F. Campbell, JD, Chief Operating Officer Apple Patch Community; Tomika H. Cosby, Executive Director Kentucky Case Management; Steve Frommeyer, Parent of a recipient of waiver services; Leigh Denniston of Almcare; Diane Quarles-Hartman, BS/MHA, Executive Director, Evergreen Life Services; Pamela J. Millay, R.N., J.D, Clinical Director/CPO Redwood; Myra Gribbins, Owner/Executive Director Reach for the stars Case Management; and Brad Schneider Vice President, Developmental Services Division LifeSkills, Inc. stated the following:

“Supports for Community Living Waiver are NOT a medical model and the participants who receive supports are NOT patients. Agencies should not be required by regulation to employ or contract with nurses when there is no nursing service for reimbursement and more importantly that SCL is not a medical model and should not be regulated as such.”

(b) Response: In 2012, the residential rates were increased by $4.00 per person per day to support registered nurse activities associated with health screening and medication administration training by the agencies. This equates to almost $6 million in reimbursement to provider agencies per year.

Evidence supports that there exists a significant cost factor for detected and/or undetected health issues. Significant time can be focused on behavioral issues that may well have their root cause in medical issues and drug interactions. The goal here is to find better strategies and solutions to help people in health management. Research has clearly demonstrated that as health improves, support needs and overall cost of care decreases.

(46) Subject: Respite

(a) Comment: Lisa A. (Chaplin) Wise, BS Special Edu, Assistant Director Communicare made the following comment:

“Section 4:Covered Services Respite; Would the participant be ineligible to receive Respite if the primary caregiver is a paid PDS Employee providing Personal Assistance?”

(b) Response: That is correct. The regulation requires that respite be provided “on a short-term basis due to the absence or need for relief of a non-paid primary caregiver.”

(47) Subject: Other Issues

(a) Comment: Maria Alagia Cull, ResCare made the following comment:

“Another issue that must be addressed is the uniform application of the regulation across all providers in the state. The Department must cross-train its staff to understand the basic elements of the program and the services required to fulfill participants' needs. Violations or issues of noncompliance should be addressed in the same manner with the same suggested corrections, which should be based on the regulation. Failure to apply consistent application of the law results in confusion and an inability to best serve the needs of SCL waiver participants. Based on our experience with Technology Assistance waivers and reimbursement in other states, ResCare suggests that Kentucky look at the reimbursement rates in Ohio.”

(b) Response: Thank you for your comment. The Cabinet is always open to improvement.

(48) Subject: Regulations Not Family Friendly

(a) Comment: David Coons, family home provider, made the following comment:

“It sure seems like all we do is try to keep up with an ever increasing set of regulations. My wife and I are a family home provider; we have three SCL individuals who live with us in our home. I just find it ironic that here we have three individuals who live with us and our family, in the community, and recently we received a letter stating that we are presumed NOT to be home and community based, and require heightened scrutiny. Seriously? I have found that the regulations we follow are definitely NOT family friendly, at best, but rather strangling. We live in fear that the state will come in and take pay back, when we are doing our jobs well. But we keep plugging away at it, knowing that we really ARE making a difference in the lives of those who live with us. Please see the attachments for comments compiled by KAPP members. I am in total agreement with those comments. Thank you for your consideration.”

(b) Response: Thank you for expressing your concerns and comments.

(49) Subject: Thank You to the Cabinet

(a) Comment: Chris Stevenson, President of Cedar Lake, made the following comment:

“I will say this about the Cabinet and that’s why my remarks following are so important. The Cabinet has worked specifically with Cedar Lake. We also are a provider of ICF services and we realize the gap in services between the waiver, the really capitated -- you know, over a decade capitated rate services here, and then you’ve got the robust services and reimbursement of an intermediate care facility. The gap was there. Many of those folks that are in an institution, if you will, -- although we wouldn’t call Cedar Lake Lodge an institution at all - it’s a wonderful facility - they’re now able to move into a regular neighborhood in the community because of the creation of a four-bed intermediate care facility. We’re actually building two of those and we’re building another two next year. And that was created in concert with the Cabinet to help create this new regulatory piece and facility regs, reducing it. So, very creative approach to it which we’re thankful for and it allows those individuals to finally -- who have intensive medical needs, to truly get the services that they need in the community in a regular neighborhood and that’s what the waiver system is truly all about.”

(b) Response: Thank you for your comment and support. We appreciate it.

(50) Subject: Direct Support Professionals/Administrative Burden

(a) Comment: Chris Stevenson, President of Cedar Lake, made the following comment:

“I believe the statistic that I heard recent is that there’s 11,000 Kentuckians with an intellectual or developmental disability who have an aging caregiver over the age of 70.

That's a disturbing statistic and says so much about what is to come over the decade as far as needs of services. The competition for our direct support professionals, these folks -- we say that they're the backbone. But unless we pay them the wages that they need, we're really lying to them. Competition is great from minimum wage service jobs in the fast-food industry. Many of them when you go to them and you say, you know, well, how can we keep you, they say I need a second job. I need more per hour. I'm a single mom. The socioeconomics of the DSP is that many of them have children, they're single moms, they have second jobs. And while we would like them to meet the pinnacle of their job and give them more education and say can't you become -- you know, maybe you can work in community access. They're saying I don't have the time to do it. I've got to care for mom or dad or whoever. And that creates a challenge for them. And with over a decade old rates, you can't pay them more. So, of course, they're going to look to try to feed their family. And, disturbingly, we've had three different organizations -- non-profit organizations come to Cedar Lake specifically and ask to join arms, whether it's through acquisition or merger or something creative, because they can't do it any longer. The administrative burden is great for them. The competition is out there when it comes to supported employment, day programs. And they're finding that it's becoming too burdensome for them. And that's really sad because I feel that the sister organizations in the non-profit realm are really the lifeblood, the grass roots that provide the true quality of care. Not saying that others don't; but these small moms and pops, they really have their hearts and souls in it. So, rather than -- it's kind of a silent killer when it comes to the lack of funding that we continue to receive; because rather than the guillotine of cuts, it's more of asphyxiation through lack of funding. And, then, over time, you're finding the moms and pops are just dying off because of the lack of the necessary oxygen or funding that they need. We've got to remind the Cabinet about how important it is that the -- what Medicaid was created for. It's for what we're doing in this room. And we've got to get loud, we've got to get bold, and we've got to make sure that our families are still actively engaged. I would have loved to have seen this room absolutely packed to capacity, but that's why we have to fight and remind our stakeholders to get involved and be so involved."

(b) Response: Thank you for expressing your comments and providing input. Home and community-based waiver programs –which are funded primarily by the federal government (Centers for Medicare and Medicaid Services) – are a critical source of care for vulnerable individuals. Unfortunately, the programs are susceptible to abuse, fraud, and exploitation and CMS as well as state agencies must ensure that taxpayer funds are actually spent on meeting the needs of participants. One component of monitoring is ensuring – like Medicaid state plan services – that services are appropriate for individuals as well as documented. CMS audits Medicaid home and community based waiver programs and can recoup federal funds due to insufficient documentation. Unfortunately, cabinet employees have much experience with providers who exploit or abuse these programs; thus, safeguards for individuals receiving services as well as safeguards to ensure services are actually delivered and appropriate are needed. DMS always welcomes input regarding how to improve the programs.

(52) Subject: Involve Providers More

(a) Comment: Chris Stevenson, President of Cedar Lake, made the following comment:

“I’m asking the Cabinet to take the time to consider our solutions to provide exceptional care for our most vulnerable citizens in Kentucky. Invite us to the table. Help us create new services as far as the gaps in support and in the future, consider creating individually-funded supports based on the individual needs of the people rather than a capitated rate that is straight across the board. That doesn’t make sense. It doesn’t work and other states are doing it well.

There’s other models that Kentucky can follow and I think now it’s time more than ever that Kentucky gets on board with what other states are doing well in taking those best-practices approach. The dam has already broke when it comes to the Michelle P. Waiver and the funding is flowing out to others that don’t necessarily need it or are appropriate for them. So, we ask for them to consider bringing us to the table and having us work in partnership and collaboration with them, enhancing communication, not being fearful to bring us to the table but to be active participants in solutions.”

(b) Response: Thank you for the offer to provide input. DMS and DBHDID welcome any input.

(53) Subject: Regulations are Burdensome and are Barriers to the Participants

(a) Comment: Jodi Wilson, Regional Director, ResCare, made the following comment:

“The community-based model has actually decreased the cost of care for many individuals while improving their overall quality of life. However, following an in-depth review of the current regulations proposed, it’s our experience and assessment that several of the regulations are unduly burdensome to providers resulting in increased barriers to the individuals that we have a duty and obligation and a desire to support.

These recent amendments also provide no benefit to anybody. The Department for Behavioral Health, Developmental and Intellectual Disabilities is currently in a unique and challenging position. The opportunity now exists to partner closely with invested providers, families, caregivers, and professionals to develop a set of regulations that are innovative in this field and help promote people with intellectual and developmental disabilities. The appropriate regulatory changes can greatly improve the lives of people it’s designed to support. Unfortunately, the recent changes made to the waiver did not clearly demonstrate divergent thinking by the department.

The existing SCL waiver demonstrates the lack of an appropriate analysis of how current regulations impact individuals across the Commonwealth and I think many of us have shared those comments today.

The regulations also don’t fully consider the scope of a person’s life from childhood through death. People will continue to be challenged in receiving the full support they

require in order to improve their quality of life start to finish. As a result, people who are genuinely committed to supporting people with disabilities will remain challenged when finding ways to help them achieve their goals. There are numerous examples and concerns that ResCare will submit in its formal response."

(b) Response: Thank you for expressing your comments and concerns.

(a) Comment: Jodi Wilson, Regional Director, ResCare, made the following comment:

"The existing SCL regulations currently impose extremely costly burdens on Kentucky's network of private service providers. In all the states in which ResCare Residential Services operates, Kentucky is the most challenging and highly-regulated waiver service environment with limited improvements in service recipient outcomes. Personally, I am not proud about that fact, but I know we've got the room full of people to change this.

There are several states operating waiver programs with improved outcomes serving as examples of successful program design. Currently, the waiver program in Kentucky does not support the premise that increased regulation improves service quality. Kentucky's team should learn from these states and improve upon those innovative designs, offering solutions that make a difference and make Kentucky a leader in this field for individuals that we serve and we care about.

In fact, the additional requirements in the regulation required the implementation of unfunded mandates that have actually taken time away from the direct implementation of quality supports to service recipients, resulting only in paper compliance models. Although the current SCL regulations are intended to improve service and quality, many of the provisions actually weaken service provider efforts to properly support individuals due to burdensome regulations and unfunded mandates taking the system back to a bygone era when an institutional medical model was entrenched.

Several provisions within the SCL regulations are actually at odds with waiver values and impose institutional practices within an individual's home. For example, some of the regulations require oversight and even implementation of certain services by a registered nurse, yet service providers receive no reimbursement for the offset to the additional expenses resulting from this new requirement."

(b) Response: Thank you for the comments. DMS and DBHDID employees research and assess other states' home and community based waiver programs – as well as receive much input from the federal agency which oversees such programs (Centers for Medicare and Medicaid Services) and are always open to input as to how to improve Kentucky's programs.

(a) Comment: Colonel Mark Scureman spoke about his experience with his daughter including her experience with schooling/educational system and stated that he and his wife concluded that "when it comes to Special Ed, the only thing that counts . . . without

a doubt is the attitude of the teacher, period, and it had nothing to do with degrees, it had nothing to do with anything else. It had everything to do with their attitude."

Colonel Scureman also spoke of how initially the meetings he and his wife had with his daughter's teachers were wonderful and the teachers were very engaged and had lengthy discussions but as the administrative burdens evolved over time the teachers had less and less to say as their time was preoccupied with completing various forms "just to satisfy the bureaucrats and satisfy the regulators."

Colonel Scureman indicated that the same thing is happening with the waiver programs and stated the following:

"There's got to be a better way. You know, lighten up on the people that are providing and I will tell you from the 48 years I've been involved with it the people closest to my daughter are the most important and what you're doing as far as I'm concerned is you're beating up on the very people that we're counting on. And don't do that.

The idea is to build a partnership, and it's between us and them. And I get the idea -- and one of the things that really bugs me is people I've never met and people that I don't know anything about it will have the gall to stand up and say to me we're only here --we're looking out for your daughter's best interest, as if we're not or as if the teachers aren't or as if the providers are not. And I said the providers are the ones that know how to do this."

Colonel Scureman indicated this is daughter works at Wendy's and stated the following:

". . . these regulations don't do anything to help what happens at Wendy's. It goes back to one lady at Wendy's who is making it happen." He also indicated that his daughter has received supported employment for over twenty years. He stated "all these regulations that were written to make sure that my daughter is taken care of don't address exactly what we're doing, which is take care of the people who said they're going to take care of her."

Coleman Scureman noted that he helped find a day training program for his daughter and noted that his daughter receives services there two to three days a week in addition to working at Wendy's three days a week. He indicated that his daughter receives day training at St. Mary's and that St. Mary's now has an employee whose "whole job is to satisfy the regulators and it costs us a lot of money and they're not helping us as far as I'm concerned." Regarding the regulators he also stated the following: "They don't even know who my daughter is and they're yelling at the very people that we're counting on for our services and, so, I would ask that you really think about the burdens." He also stated: Your job, I think, is to help the providers help us and they will tell you what they need and the other thing that really bugs me is playing one against the other."

Colonel Scureman compared the day training program (St. Mary's) with the supported employment program (Wendy's) and indicated that his daughter develops friends at the

day training program in contrast to the supported employment program; however, there's a requirement now that his daughter can only go out (as part of day training service) with two or no more than three people at a time and questioned who came up with such a restriction. He indicated that St. Mary's knows what his daughter wants and the regulators should be listening to the providers rather than the other way around.

Coleman Scureman also indicated that many times over the years he's seen staff have to leave due to low pay and/or a new educational requirement that they don't meet. He questioned why are such requirements imposed all of a sudden and stated the following:

"Some of the best people that we have that are working, somehow somebody has deemed that they're not qualified because they don't have a degree. Well they've got a degree in knowing how to serve my daughter, I'll tell you that. And why are we doing this? Why are we doing this? So, all I would say to you is I hope – and I've been through with Mr. Hall and all these folks like this a couple of years ago and the idea that in 2013 we said this is what we need and we're getting up and saying we still need it, you know. Are you really listening to what they're having to say?"

(b) Response: DMS and DBHDID employees appreciate and welcome your comments and most of all your perspective. Finding the right balance between rules and requirements and flexibility is not easy. Unfortunately, as with many taxpayer-funded programs there are individuals who exploit and abuse such programs – at the expense of program participants and of course taxpayers – and who not only provide little or no services to participants but jeopardize their health, welfare, and safety. DMS and DBHDID employees have encountered far too many such individuals and the result is that rules are revised in part to stop or deter the abuse or exploitation of individuals the program is intended to serve as well as abuse and exploitation of taxpayer funds.

The majority of funding is provided by the Centers for Medicare and Medicaid Services (federal agency) and CMS attaches requirements to the funding to ensure that taxpayer funds are actually spent appropriately and on appropriate care and services provided to individuals. Documentation of such services (which is one example of an administrative burden) is critical to demonstrate that funds are actually being spent on care to individuals receiving services and that the services are appropriate for the individual.

CMS audits these programs and can recoup payments made if insufficient documentation of services and the necessity/appropriateness of services does not exist. Additionally, the Kentucky Office of the Auditor of Public Accounts audits Kentucky's Medicaid Program for similar reasons.

SUMMARY OF STATEMENT OF CONSIDERATION
AND
ACTION TAKEN BY PROMULGATING ADMINISTRATIVE BODY

The Department for Medicaid Services (DMS) has considered the comments received regarding 907 KAR: 12:010 and is amending the administrative regulation as follows:

Page 6
Section 1(16)(b)2.b.
Line 12
After “approved”, insert “training program”.
Delete “credential”.

Page 7
Section 1(17)(c)
Line 10
After “in”, insert Sections”.
Delete “Section”.

After “3”, insert “and 10”.

Page 9
Section 1(25)(c)
Line 11
After “in”, insert Sections”.
Delete “Section”.

After “3”, insert “and 10”.

Page 11
Section 1(34)
Line 22
After “service”, insert “plans”.
Delete “budgets”.

Page 17
Section 1(64)
Line 21
After “’MWMA”, delete “portal”.

Page 25
Section 1(92)(d)
Line 13
After “Section”, insert “10”.
Delete “3”.

Page 27
Section 1(99)(b)1.
Lines 3 and 4

After “Has”, delete the following:

at least a bachelor’s degree from an accredited college or university and one (1) year of experience in the field of developmental disabilities;

Page 27
Section 1(99)(b)2.
Line 5

Before “2.”, delete “2. Has”.

Page 27
Section 1(99)(b)3.a.
Line 8

Renumber this subparagraph by inserting “2.” and deleting “3.”.

Page 27
Section 1(99)(b)3.b.
Line 10

After “department”, insert “required training program”.
Delete “approved credential”.

Line 13

After “~~basis~~];”, insert “and”.

Page 27
Section 1(99)(c)
Line 14

After “in”, insert “Sections”.
Delete “Section”.

After “3”, insert “and 10”.

Page 27
Section 1(99)(c) and (d)
Lines 15 to 18

After “regulation”, delete the following:

; and
(d) Sequentially completes the Kentucky Supported Employment Training Project curriculum from the Human Development Institute at the University of Kentucky within eight (8)

Page 27
Section 1(99)(d)
Line 18

After “[~~six (6)~~]”, delete the following:

months of the date of employment as an employment

Page 27
Section 1(99)(d)
Line 18
After "[~~the~~]", delete "specialist".

Page 28
Section 2, Title
Line 6
Before "Section 2.", insert the following:
(102) "Voluntary moratorium" means a provider's voluntary agreement to not serve any new (to the provider) 1915(c) home and community based waiver services participants.

Page 28
Section 2(1)(a) and (b)
Lines 8 to 10
After "(a)", delete the following:
Shall be screened by the department for the purpose of making a preliminary determination of whether the individual might qualify for SCL waiver services; (b)

Page 28
Section 2(1)(b)1.
Line 11
After "MWMA", delete "portal".

Page 28
Section 2(1)(b)2.
Line 13
After "MWMA", delete "portal".

Page 28
Section (2)(1)(c)
Line 15
Renumber this paragraph by inserting "(b)" and by deleting "(c)".

Line 16
After "Section", insert "12".
Delete "10".

Page 28
Section 2(1)(d), (e), and (f)
Lines 17, 19, and 21
Renumber these three paragraphs by inserting "(c)", "(d)", and "(e)", respectively, and by deleting "(d)", "(e)", and "(f)", respectively.

Page 28
Section 2(1)(f)
Line 22
After “MWMA”, delete “portal”.

Page 29
Section 2(2)(a)1.
Line 10
After “months”, insert the following:
from the level of care end date

Page 34
Section 3(3)(e)5.b.(iii)
Line 14
After “assistance;”, insert “and”.

Page 34
Section 3(3)(e)5.b.(iv) and (v)
Lines 16 and 17
After “community;”, delete the following:
and
(v) Improve the participant’s competence;

Page 40
Section 3(3)(o)
Line 5
After “MWMA”, delete “portal”.

Page 40
Section 3(3)(o)5.c.
Line 20
After “Assessment”, insert “profile”.
Delete “Form”.

Page 41
Section 3(3)(o)5.d.(i)
Line 1
After “personnel”, insert the following:
using the department approved protocol

Page 42
Section 3(3)(o)5.p.
Line 3
After “MWMA”, delete “portal”.

Page 45

Section 3(3)(y)1.
Line 11
After “abuse registry checks,”, delete “and”.

Line 11
After “central registry checks”, insert the following:
, and caregiver misconduct registry checks

Line 12
After “employees;”, insert “and”.

Page 45
Section 3(3)(y)2. and 3.
Lines 13 to 16
After “employees;”, delete “and” and delete subparagraph 3 in its entirety.

Page 49
Section 3(3)(ff)1.
Line 22
After “supervisor”, insert “, licensed professional,”.

Page 50
Section 3(3)(ff)2.
Line 1
After “hours of”, insert “competency-based”.

Page 50
Section 3(3)(ff)3.
Line 4
After “hours of”, insert “competency-based”.

Page 62
Section 4(4)(n)
Line 7
After “MWMA”, delete “portal”.

Page 63
Section 4(5)(a)5.
Line 22
After “documented”, insert “in the MWMA”.

Page 66
Section 4(6)(f)
Line 17
After “MWMA”, delete “portal”.

Page 69
Section 4(7)(b)8.
Line 14
After “Documentation”, insert “in the MWMA”.

Page 69
Section 4(7)(b)8.g.
Line 23
After “record;”, insert “and”.

Page 70
Section 4(7)(c) and (d)
Lines 1 and 2
After “year”, delete “; and”, and delete paragraph (d) in its entirety except for the period.

Page 72
Section 4(8)(h)
Line 18
After “documentation”, insert “in the MWMA”.

Page 74
Section 4(9)(a)5.
Line 17
After “MWMA”, delete “portal”.

Page 76
Section 4(10)(a)8.
Line 7
After “MWMA”, delete “portal”.

Page 78
Section 4(11)(a)8.
Line 14
After “MWMA”, delete “portal”.

Page 83
Section 4(12)(d)
Line 5
After “shall”, enter the following:
be entered in the MWMA and shall

Page 85
Section 4(13)(i)
Line 3
After “documented”, insert “in the MWMA”.

Page 89
Section 4(14)(a)3.k.
Line 16
After “k.”, insert the following:
Clarify in measurable terms the frequency, intensity, and duration of the target behaviors:
(i) That will signify that a reduction in services is in order; and
(ii) When services are at an end;
l.

Page 90
Section 4(14)(a)3.l. and k.
Lines 2 and 4
Renumber these two clauses by inserting “m.” and “n.”, respectively, and by Deleting “l.” and “m.”, respectively.

Page 92
Section 4(15)(g)2.
Line 10
After “documented”, insert “in the MWMA”.

Page 95
Section 4(17)(a)1.b.
Line 21
After “who”, insert the following:
through the use of technology assisted residential services reduce the amount of in-home

Delete the following:
reside in the residence with twenty-four (24) hour

Page 102
Section 4(19)(a)3.
Line 5
After “documented”, insert “in the MWMA”.

Page 103
Section 4(20)(g)
Line 19
After “meet”, insert the following:
the participant-directed services provider requirements established
Delete “direct support professional qualifications”.

Line 20
Before “Section”, delete “accordance with”.

After “Section”, insert “10”.
Delete “1(23)”.

Page 104
Section 4(20)(j)1.
Line 5
After “MWMA”, delete “portal”.

Page 106
Section 4(21)(a)10.
Line 5
After “MWMA”, delete “portal”.

Page 109
Section 4(22)(c)2.a.
Line 11
After “MWMA”, delete “portal”.

Page 111
Section 4(22)(f)2.
Line 8
After “MWMA”, delete “portal”.

Page 114
Section 4(22)(f)10.a.
Line 13
After “MWMA”, delete “portal”.

Page 117
Section 4(24)(a)6.
Line 18
After “MWMA”, delete “portal”.

Page 122
Section 5(3)(a)1.
Line 15
After “MWMA”, delete “portal”.

Page 122
Section 5(3)(a)2.
Line 16
After “MWMA”, delete “portal”.

Page 122

Section 5(3)(b)
Line 18
After “MWMA”, delete “portal”.

Line 19
After “MWMA”, delete “portal”.

Page 126
Section 6(2)(m)
Line 3
After “MWMA”, delete “portal”.

Page 126
Section 6(2)(n)
Line 12
After “MWMA”, delete “portal”.

Page 126
Section 6(2)(n)6.
Line 19
After “address;”, delete “and”.

Page 127
Section 6(2)(o)3.*
Line 1
After “guardian”, insert the following:
; and
(p) Be supervised by a case management supervisor
**NOTE: In the filed version subparagraph 2. Stated “At least annually thereafter and upon inquiry from the participant or participant’s guardian”; however, via a post-filed technical amendment this was divided into a subparagraph 2. and a new subparagraph - subparagraph 3. - as follows:*

“2. At least annually therafter; and
3. Upon inquiry from the participant or participant’s guardian.”

Page 127
Section 6(3)(b)2.d.
Line 20
After “MWMA”, delete “portal”.

Page 129
Section 6(4)(e)2.
Line 6
After “utilize”, insert “the MWMA”.
Delete the following:

A DBHDID-approved monitoring tool

Page 129
Section 6(4)(e)3.b.(ii)
Line 14
After “in”, insert “identifying strategies for”.

Page 131
Section 6(4)(l)
Line 2
After “MWMA”, delete “portal”.

Page 131
Section 6(6)
Line 17
Renumber this subsection by inserting “(5)” and by deleting “(6)”.

Page 131
Section 6(7)
Line 20
Renumber this subsection by inserting “(6)” and by deleting “(7)”.

Page 132
Section 7(4)
Line 19
After “of”, insert “at least six (6)”.
Delete “eight (8)”.

Page 134
Section 8(2)
Line 22
After “(2)”, insert “(a)”.

Page 135
Section 8(3)
Line 2
Before “(3)”, insert the following:

(b) A Behavior Intervention Committee meeting shall have a quorum of at least five (5) members including at least one (1):
1. Self-advocate, representative, or family member;
2. Member from the community at large with experience in:
a. Human rights issues; or
b. The field of intellectual or developmental disabilities;
3. Professional in the medical field;
4. Positive behavior support specialist; and
5. Professional comprised of any combination of a:

a. Positive behavior support specialist;
b. Licensed psychologist;
c. Certified psychologist; or
d. Licensed clinical social worker.

Page 136
Section 10(1)(a)
Line 23
After “the”, insert “: 1.”.

Page 137
Section 10(1)(a)
Line 1
After “regulation”, insert the following:
except for the monthly summary note requirements established in Section 4 of this administrative regulation;

Line 2
After “and”, insert “2.”
Delete “the”.

Page 137
Section 10(1)(a)1., 2., 3., 4., 5., 6., and 7.
Lines 4, 5, 6, 7, 8, 9, and 10
Renumber these seven subparagraphs by inserting “a.”, “b.”, “c.”, “d.”, “e.”, “f.”, and “g.”, respectively, and by deleting “1.”, “2.”, “3.”, “4.”, “5.”, “6.”, and “7.”, respectively.

Page 137
Section 10(1)(b)
Line 11
After “the”, insert the following:
:
1. Background and related requirements established in Section 3(3)(p), (q), (r), (u), (w), (x), (y), and (z) of this administrative regulation; and
2.

Page 137
Section 10(1)(b)1., 2., 3., and 4.
Lines 14, 16, 21, and 23
Renumber these four subparagraphs by inserting “a.”, “b.”, “c.”, and “d.”, respectively, and by deleting “1.”, “2.”,”3.”,and “4.”, respectively.

Page 137
Section 10(1)(b)4.a.
Line 23

Renumber this clause by inserting “(i)” and by deleting “a.”.

Page 138
Section 10(1)(b)4.b., c., d., and e.
Lines 1, 2, 3, and 4
Renumber these four clauses by inserting “(ii)”, “(iii)”, “(iv)”, and “(v)”, respectively, and by deleting “b.”, “c.”, “d.”, and “e.”, respectively.

Page 138
Section 10(1)(b)5.
Line 5
Renumber this subparagraph by inserting “e.” and by deleting “5.”.

Page 140
Section 10(4)(j)2.
Line 13
After “MWMA”, delete “portal”.

Page 141
Section 10(5)(e)2.
Line 7
After “MWMA”, delete “portal”.

Page 141
Section 10(7)(e)1.
Line 22
After “reports”, insert “monthly”.
Delete “semi-monthly”.

Page 142
Section 10(9)(a)
Lines 15 and 16
After “(9)(a)”, insert “A”.
Delete the following:

> If case management monitoring reveals that a participant’s health, safety, or welfare is being jeopardized, the

Page 142
Section 10(9)(a) and 1.
Lines 16 and 17
After “shall”, delete the colon, the return, and the notation “1.”

Page 142
Section 10(9)(a)1. and 2.
Lines 18 and 19
After “member”, insert the following:

if:
1. The participant does not comply with the participant's person-centered service plan;
2. The participant, a family member of the participant, an employee of the participant, the participant's guardian, or a legal representative of the participant threatens, intimidates, or consistently refuses services from an SCL provider;
3. Imminent threat of harm to the participant's health, safety, or welfare exists; or
4. The participant, a family member of the participant, an employee of the participant, the participant's guardian, or a legal representative of the participant interferes with or denies the provision of case management.
(b) The participant's case manager shall

Delete "; and
2."

Page 142
Section 10(9)(a)2.
Line 20

After "the", delete "health, safety, or welfare".

After "issue", insert the following:
described in paragraph (a) of this subsection that necessitated a corrective action plan

Page 142
Section 10(9)(b)
Line 21

Renumber this paragraph by inserting "(c)" and by deleting "(b)".

After "the", delete "health, safety, or welfare".

Page 143
Section 10(9)(c)
Line 3

Renumber this paragraph by inserting "(d)" and by deleting "(c)".

Page 144
Section 11(4)(a) and (a)1.
Lines 14, 15, and 16

After "occurs, the", insert a colon, a return, and "1.".

After "shall", insert the following:
document the details of the incident and

Delete the colon and delete the notation "1.".

Page 144
Section 11(4)(a)1.
Line 16
After “report”, insert the following:
it to agency staff for

Delete the following:
the incident by making an

Lines 16 and 17
After “MWMA”, delete the following:
portal that includes details regarding the incident

Page 144
Section 11(4)(a)2.
Line
After “2.”, insert “Incident shall”.

Page 145
Section 11(5)(b)1.
Lines 17 and 18
After “MWMA”, delete the following:
portal by the individual who witnessed or discovered the critical incident

Page 145
Section 11(5)(b)2.
Line 17
After “MWMA”, delete “portal”.

After “by”, insert the following:
a designated agency staff person
Delete the following:
the individual who witnessed or discovered the critical incident

Page 146
Section 11(5)(c)2.
Line 16
After “MWMA”, delete “portal”.

Page 147
Section 11(6)(a)
Line 14
Before “[~~following~~”, delete “portal”.

Page 149

Section 11(7)(a)
Line 4
After “MWMA”, delete “portal”.

Page 149
Section 12(1)(a)1.
Line 11
After “MWMA”, delete “portal”.

Page 149
Section 12(1)(a)2.
Line 14
After “MWMA”, delete “portal”.

Page 149
Section 12(1)(b) and (c)
Lines 15 to 19
After “(b)”, delete the remainder of paragraph (b) in its entirety and delete the notation “(c)”.

Page 149
Section 12(1)(c)
Line 20
After “MWMA”, delete “portal”.

Page 150
Section 12(1)(d) and (e)
Lines 4 and 11
Renumber these two paragraphs by inserting “(c)” and “(d)”, respectively and by deleting “(d)” and “(e)”, respectively.

Page 151
Section 12(3)(a)1.
Line 12
After “MWMA”, delete “portal”.

Page 153
Section 12(5)
Line 5
After “MWMA”, delete “portal”.

Page 157
Section 14, Title
Line 8
After “14.”, insert the following:
Corrective Action Plans. (1)(a) If a provider receives a findings report from the

department indicating that an issue of non-compliance has been cited, the provider shall have ten (10) business days from the date on the letter that accompanied the findings report to submit a corrective action plan to the department in accordance with the instructions in the letter.

(b) If a provider is notified by the department that the corrective action plan was not approved, the provider shall submit a revised corrective action plan to the department within ten (10) business days of the date on the letter informing that the initial corrective action plan was not approved and in accordance with the instructions in the letter.

(c)1. If a provider is notified by the department that the second corrective action plan was not approved, the provider shall submit a revised corrective action plan to the department within five (5) business days from the date on the letter notifying that the second corrective action plan was not approved.

2. If the third corrective action plan submitted to the department is not approved, the department shall:

a. Not certify the provider if the provider is new;

b. Not recertify the provider if the provider is an existing provider; or

c. Terminate the provider's certification.

3. A provider shall have the right to appeal a termination in accordance with 907 KAR 1:671.

4. A citation of an issue of non-compliance shall not be appealable.

(2) The department shall have up to thirty (30) business days to review a corrective action plan.

Section 15. Provider Certification. The following shall apply regarding SCL provider certification periods:

Provider Status at Recertification Date	New Certification Period Based on Status at Recertification Date
Zero citations during the prior twenty-four (24) month period	Two (2) Years
Zero citations during the most recent recertification review and have successfully implemented any approved corrective action plan for any citation issued during the recertification period if any citation was issued	One (1) year

Received citations during the most recent recertification review or has existing (open) citations without either an accepted corrective action plan or a successfully implemented corrective action plan	Six (6) Months (1) Upon approval of corrective action plan, the department shall monitor for successful implementation within thirty (30) days. (2) Upon successful implementation of corrective action plan, the department shall extend recertification to balance of one (1) year. (3) If provider fails to implement an approved corrective action plan, the department shall extend the timeframe for implementation or consider non-renewal or termination. (4) If provider has not submitted an approved corrective action plan after the three (3) allowed attempts (see above), the department shall consider non-renewal or termination.

Section 16. Voluntary Moratorium. (1)(a) Upon the department becoming aware of a potential health, safety, or welfare violation, the department shall contact the provider's executive director to:

1. Officially notify the provider of the option for a voluntary moratorium; and
2. Discuss the health, safety, or welfare concern.

(b) The department's notice to the provider shall initially be made via phone followed up by notice via electronic means.

(c) Upon receipt of the electronic notice, the provider shall formally accept or not accept the voluntary moratorium option by:

1. Signing the document provided; and
2. Returning it to the department within two (2) business days of receipt by electronic means as directed in the electronic notice.

(2) If the provider:

(a) Agrees to a voluntary moratorium, the department shall proceed as established in 907 KAR 7:005 regarding a voluntary moratorium pending an investigation; or

(b) Does not agree to a voluntary moratorium, the department shall:

1. Terminate the provider in accordance with 907 KAR 7:005; and
2. Notify in writing the provider's executive director at the agency's primary business address of the:

a. Reason for termination; and

b. Provider's right to appeal the termination within:

(i) Two (2) business days of receipt of the written non-acceptance of the voluntary moratorium; or
(ii) Five (5) business days of the initial notice sent to the provider if the provider did not respond to the notice of the voluntary moratorium option.
(3) A notice of termination to the provider shall be sent via a delivery method that records the sending and receipt of the notice.
(4)(a) If a provider is terminated, the department shall:
1. Monitor the provider's efforts to ensure the health, safety, and welfare of participants in need of being transitioned to a new provider; and
2. Provide technical assistance to the provider during the transition.
(b) A provider shall:
1. Fully cooperate with the department's transition assistance team and any other state government agency involved;
2. Provide full access to its records and information pertaining to the participants being transitioned; and
3. Be responsible for facilitating the effective transition of participants to another provider or providers of the participant's choice prior to the termination date.
(c) A provider's termination date shall be stated in the termination notice.
(d) A participant's case manager shall help ensure that the participant's transition to a new provider or providers is completed prior to the termination date.
Section 17.

Page 157
Section 15 and 16
Lines 11 and 21
Renumber these two Sections by inserting "18." and "19.", respectively, and by deleting "15." and "16.", respectively.

Page 158
Section 17
Line 9
Renumber this Section by inserting "20." and by deleting "17.".

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Section 17(1)(f)
Line 22
After "Exemption',", insert "October".
Delete "May".